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SENATE

REPORT
No. 95-1111

MEDICARE-MEDICAID ADMINISTRATIVE AND REIMBURSEMENT REFORM ACT

AUGUST 11 (legislative day, MAY 17), 1978.—Ordered to be printed

Mr. LONG, from the Committee on Finance, submitted the following

REPORT

[To accompany H.R. 5285]

The Committee on Finance, to which was referred the bill (H.R. 5285) to amend the Tariff Schedules of the United States with respect to the tariff treatment accorded to film, strips, sheets, and plates of certain plastics or rubber, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill as amended do pass.

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I. Summary of the Bill

As reported, the provisions of S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act as amended by the committee and added as an amendment to H.R. 5285 address three major areas: hospital reimbursement, practitioner reimbursement, and long-term care. The summary presented below briefly outlines the bill as reported.

HOSPITAL REIMBURSEMENT REFORMS

1. The bill establishes a new method of reimbursement for routine operating costs for hospitals under the medicare and medicaid programs. The new mechanism, to be effective July 1, 1979, would provide for incentive reimbursement—rewarding hospitals whose routine operating costs are below average, and penalizing hospitals whose routine operating costs are substantially above average.

Comparisons among institutions would be facilitated by:

Classifying hospitals in groups, by bed size, location, type of hospital, or other categories found to be appropriate;

Applying the reimbursement system to routine operating costs (for example, routine nursing, administrative, maintenance, supply, and food costs), and excluding elements of routine costs such as costs of capital, costs of education and training programs, malpractice insurance, etc. Such excluded costs would continue to be reimbursed as under current law.

A target rate for routine operating costs would be determined for each hospital by:

Calculating the average per diem routine operating cost for the hospitals in each classification group; and

Adjusting the personnel cost component of the group average to reflect the difference in wages in effect in each hospital's area.

Hospitals whose actual routine operating costs fell below their target rate would receive one-half of the difference between their costs and their target rate, with the bonus payment limited to 5 percent of the target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their payment rate would have their reimbursement limited to 115 percent of the target rate. Beginning with the second year, the reimbursement limit would be reduced below the 115 percent level.

Provision is made for a hospital to demonstrate that its unusually high routine costs are caused by (1) underutilization of beds or facil-

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ities, but only where such beds or facilities are necessary to meet the needs of an underserved area, (2) an unusual patient mix which results in a greater intensity of routine care, (3) changes in services due to approved consolidations or sharing of services with another hospital, and (4) start-up costs associated with a new hospital. To the extent that such additional costs could be justified, they would be excluded from the reimbursement criteria provided for in the bill.

If the Secretary is satisfied that a State hospital reimbursement control system would result in aggregate medicare and medicaid payments to the State's hospitals for routine and nonroutine costs which are no greater than would otherwise be payable by medicare and medicaid under the system established by the bill, then payments to hospitals in that State could, at the State's request, be based on the State system. A State with an approved reimbursement control program would be reimbursed for the medicare program's proportionate share of the cost of operating the State program. The State's medicaid program would pay its proportionate share of costs which would be matchable with Federal funds as an administrative expense. In addition, medicare and medicaid would pay their proportionate share of startup costs of approved State reimbursement control programs.

The bill requires the Secretary to appoint an 11-member Health Facilities Costs Commission. The Commission would monitor and study all aspects of the cost reimbursement program and propose such changes and refinements as it found appropriate. The Commission would be directed to develop possible legislative recommendations to refine the method of reimbursing hospitals for routine costs and for the possible application of similar limitations to other hospital costs and to the costs of other providers of services, such as skilled nursing facilities, ICFs, home health agencies, and renal dialysis facilities.

To the extent not specifically otherwise provided for under the bill hospital reimbursement would be made by medicare and medicaid subject to and under the provisions of present law.

2. The bill provides for including in payments to short-term hospitals, reimbursement for increased operating costs and, in the case of nonprofit institutions, for increased capital costs associated with the closing down or conversion to approved use of underutilized bed capacity or services. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, nonprofit hospitals could continue to receive capital allowances in the form of depreciation or interest on debt in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program and actually outstanding. Appropriate safeguards are included to forestall abuse or speculation.

3. The bill includes several changes in the current law limitations on medicare and medicaid payments related to certain hospital capital expenditures. These changes link reimbursement to the health planning law by requiring that the designated planning agency approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement for capital and direct operating costs associated with those expenditures. A special procedure is established for

proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. All States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement subject to review by the Secretary. Section 1122(g) of the Social Security Act is amended to clarify that notice, approval and reimbursement penalty requirements contained in that section with respect to approval of health care facility capital expenditures do not apply to simple changes of ownership (either by purchase, or under lease or comparable arrangement) of existing and operational facilities which create no new beds or services.

PRACTITIONER REIMBURSEMENT REFORMS

1. The bill establishes the concept of "participating" physicians. A "participating" physician is an M.D. or D.O. who voluntarily agrees to accept the medicare reasonable charge determination on an assignment basis, as the full billing amount for all services to all his medicare patients. Agreements would be cancellable on the basis of 30 days' notice. "Nonparticipating" physicians could continue to elect to use the assignment method of billing on a claim-by-claim basis as under present law.

In the case of a participating physician, the Secretary would establish appropriate procedures and forms whereby such physician may submit his claims on a simplified basis. These claims would be given priority handling by the medicare carrier.

An "administrative cost-saving allowance" of $1 per eligible patient would be payable to a participating physician covering all services provided and billed for with respect to an eligible patient which were included in a multiple billing listing.

No administrative allowance would be payable in the case of claims solely for laboratory tests and X-rays undertaken outside of the office of the billing physician.

2. The bill permits medicare reimbursement to be made to free-standing ambulatory surgical centers and physicians performing surgery in their offices for the use of surgical facilities needed to perform a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient basis but can, consistent with sound medical practice, be performed on an ambulatory basis. In the physician's office, the rate would encompass reimbursement for the facility and physician, and for related services including pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure. In the case of an ambulatory surgical center, the overhead allowance may be paid directly to the center and the professional fee directly to the physician(s).

The physician performing surgery in his office would be fully compensated for his overhead costs through this rate if he accepts an assignment; there would be no deductible and coinsurance.

Similarly, deductible and coinsurance amounts would be waived for the physician's fee when the physician accepts assignment for hospital outpatient surgery.

3. The bill modifies existing medicare criteria for determining reasonable charges for physician services.

Medicare presently allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality. The bill would permit new physicians in under-served localities to be reimbursed at the 75th percentile (rather than the 50th) as a means of encouraging doctors to move into low-fee, physician shortage areas. It would also permit physicians presently practicing in shortage areas to have the fees they generally are charging recognized as reasonable, up to the 75th percentile.

Medicare utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. One State has 28 different localities. This has led to irrational disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, all prevailing charges are annually adjusted upward by a fixed percentage to reflect changes in the costs of practice and wage levels. The effect of present law is to further widen the dollar gap between prevailing charges in different localities.

The bill requires calculation of statewide median charges (in any State with more than one locality) in addition to the locality prevailing charges. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect—it would operate, to the extent given charges exceed the statewide median by more than one-third—to preclude raising them.

4. The bill amends present law to provide for direct payment to allergists for preparation of a reasonable supply of antigens which would be dispensed or administered by or under the supervision of another physician.

5. The bill includes a technical change that would permit payment by medicare for care directly to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill. Under present law, medicare can only pay where the physician accepts an assignment or where the family has actually paid the bill. Thus, in some cases where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

LONG-TERM CARE REFORMS

1. The bill includes a provision to encourage better use of underutilized beds of small rural hospitals by providing for a simplified cost reimbursement formula which avoids the current requirement for separate patient placement within the facility and separate cost finding.

2. The bill allows States the option, when computing reimbursement rates under medicaid to a skilled nursing facility or intermediate care facility, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

3. The bill includes a provision which would make the Secretary of HEW the final certifying officer for skilled nursing and intermediate care facilities under medicaid.

4. The bill prohibits the Secretary from imposing numerical limits on the number of home visits which might be made by skilled nursing home or intermediate care patients under medicaid.

GENERAL PROVISIONS

1. The bill provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under the Social Security Act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the program affected.

2. The bill terminates the Health Insurance Benefits Advisory Council (HIBAC).

3. The bill includes a provision under which reimbursement to contractors, employees or related organizations, consultants, or subcontractors would not be recognized where compensation or payments (in whole or part, in cash or kind) were based upon percentage arrangements that are not normal business practices. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization or from the original provider or organization to the supplier or service agency. However, the amendment would not preclude certain percentage arrangements which are found to be customary commercial business practices or which promote good and economical management practices.

4. The bill permits payment for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care.

5. The bill authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) institutions of higher learning. These grants would assist institutions in the training of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and providing needed services for children and young adults suffering from such diseases.

6. The bill provides that the requirements of the human experimentation statute would not apply to financial and administrative arrangements such as deductible and copayment requirements.

7. The bill includes a provision that prohibits the routine release of information relating to the amounts paid to physicians on behalf of medicare patients.

8. The bill adds a provision that requires States to deny medicaid benefits for up to a year in certain cases for aged, blind and disabled individuals who, within the preceding year, dispose of their assets for substantially less than fair market value; there would be a rebuttable presumption that such disposal was undertaken for the purpose of qualifying for medicaid.

9. The bill changes the allowed rate of return on for-profit hospitals' net equity, which under present law is equal to 1½ times the current rate of return on Social Security trust funds. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in sec. 2 of the

bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits.

10. The bill waives the $60 deductible in applying special laboratory billing procedures under medicare.

11. The bill allows a State to purchase laboratory services for its medicaid population through competitive bidding arrangements for a three-year experimental period.

12. The bill clarifies that Professional Standards Review Organizations (PSRO's) are not to be considered Federal agencies for purposes of any public disclosure of information developed or compiled in undertaking functions required under the Social Security Act.

13. The bill removes the requirement in existing law that limits medicare home health benefits to 100 visits under part A and 100 visits under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least three days before he can qualify for part A home health benefits.

14. The bill establishes a new reimbursement methodology for medical equipment whereby reasonable charges for durable medical equipment would be calculated on a prospective basis and would take into account, in addition to the customary and prevailing charges, the acquisition costs of the equipment, appropriate overhead (considering the level of delivery services and other necessary services provided by the supplier), and a reasonable margin of profit.

15. The bill requires HEW to adopt, to the extent feasible, standardized claims forms for medicare and medicaid.

16. The bill provides for medicare to share its audit findings with the medicaid and the maternal and child health programs where these programs reimburse the same entity on the basis of its reasonable costs.

17. The bill would exclude certain charitable donations for the purpose of determining the reasonable costs for reimbursement under medicare and medicaid.

18. The bill requires skilled nursing facilities (SNFs) to participate in both medicare and medicaid as a condition to participate in either program.

19. The bill extends the coverage of dental services under medicare to include any services which may be performed by a doctor of dental surgery or of dental medicine legally authorized to perform such services if they would be covered when performed by a physician.

20. The bill authorizes medicare part B reimbursement to optometrists for services related to aphakia which are within the scope of licensed optometric practice, and which are covered under present law when provided by a physician.

21. Under present law, medicare beneficiaries who exhaust their eligibility for days of hospital or SNF benefits can renew their eligibility by remaining outside a skilled nursing care institution for 60 consecutive days.

The bill directs the Secretary to review present criteria for classifying skilled nursing care institutions to ensure that the criteria for renewing benefit eligibility are not too restrictive. The Secretary would report his findings and conclusions to the Congress within 9 months, together with any legislative recommendations he may wish to propose.

22. The bill provides an additional 1-year period for States to enter "buy-in" agreements under medicare on behalf of their medicaid population.

II. General Explanation of the Bill

SECTION 2—CRITERIA FOR DETERMINING REASONABLE COST OF HOSPITAL SERVICES

The bill modifies the method of reimbursement for hospitals under the medicare and medicaid programs. Under the new method, to be effective with hospital reporting periods that begin after June 30, 1979, reimbursement for most of a hospital's inpatient routine costs (essentially costs other than ancillary expenses such as laboratory, X-ray, pharmacy, etc.) would be related to a target rate based on similar costs incurred by comparable hospitals. Costs excluded from the routine per diem calculations would be: capital and related costs; cost of education and training programs; costs of interns, residents and nonadministrative physicians; energy costs; and malpractice insurance costs. Those hospitals whose routine operating costs were below the average for comparable hospitals would be rewarded with incentive payments, and payments to those hospitals with routine operating costs which are substantially above the average would be reduced. On or before January 1, 1979, the Secretary would appoint an 11-member Health Facilities Costs Commission. The Commission would monitor and study all aspects of the cost reimbursement program and propose such changes and refinements as it found appropriate.

Expenditures for hospital care have been increasing at double-digit rates for many years. The estimated fiscal year 1977 hospital expenditure level, for example, was 14 percent above that in fiscal year 1976. Preliminary estimates indicate that expenditures for hospital care, $65.6 billion in fiscal year 1977, represent 40 percent of all national health expenditures. Hospital expenditures in fiscal year 1977 represent 3.6 percent of the GNP and $297 per capita. Historically, hospital costs per patient-day have risen much more rapidly than consumer prices in the economy as a whole. For example, while the general level of consumer prices rose by about 125 percent from 1950 to 1976, the average cost of a day of hospital care increased by more than 1,000 percent.

This rapid growth in the costs of hospital care has focused increasing attention on hospitals and the present methods currently used to reimburse hospitals. Cost-based reimbursement in particular has been the subject of widespread criticism. There is little in the way of pressure on hospitals so paid to contain their costs, since any increases are simply passed along to the third parties that reimburse on a cost basis. The present "reasonable costs" procedures under the medicare program are not only inherently inflationary—because there are no effective limits on what costs will be recognized as reasonable—but also contain neither incentives for efficient performance nor true disincentives to inefficient operation.

In a nongovernmental attempt to moderate the rate of increase in overall hospital expenditures, the American Hospital Association, the American Medical Association, and the Federation of American Hos-

pitals are leading a cost-containment activity at the State level. This so-called "voluntary effort" should not be discouraged or impaired by Federal agencies through legal or other means before it has had reasonable opportunity to demonstrate success or failure.

The method of reimbursement established by the bill would be as follows. Comparisons among hospitals would be made by:

1. Classifying hospitals in groups by bed size, type of hospital, rural or urban location, or other criteria established by the Secretary.

2. Including all routine costs (as defined in applying medicare routine cost limits under present law) except for the following variable costs: capital and related costs; costs of education and training programs; costs of interns, residents, and nonadministrative physicians; energy costs; and malpractice insurance costs.

When classifying hospitals by type, hospitals which are primary affiliates of accredited medical schools would be a separate category, without regard to bed size. The Health Facilities Cost Commission should give priority to the development and evaluation of alternative definitions and classifications for the category primary affiliates of accredited medical schools. The Commission should ensure that the treatment of these medical center/tertiary care/teaching hospitals accurately reflects the hospital's role as a referral center for tertiary care patient services, as a source for the development and introduction of new diagnostic and treatment technologies, and/or as the source of care for a high concentration of patients needing unusually extensive or intensive patient care services provided in routine service cost centers. In addition, these hospitals generally provide a broad range of graduate medical education programs and undergraduate medical clerkships. The committee recognizes that some medical schools, because of their organization and objectives, have more than one primary affiliate, and the primary affiliate classification should provide for the possibility of including more than one hospital in unusual situations. The primary affiliates category should not include affiliated hospitals which are not primary affiliates within the meaning of the concept described above.

A per diem target rate for routine operating costs would be determined for each hospital by:

1. Calculating the average per diem routine operating cost for each group of hospitals under the classification system (excluded would be newly-opened hospitals and hospitals which have significant cost differentials because they do not meet standards and conditions of participation as providers of services); and

2. Determining the per diem rate for each hospital in the group by adjusting the labor cost component of the group's average per diem routine costs for area wage differentials. In the first year of the program only, an adjustment would be allowed where the hospital can demonstrate that the wages paid to its employees are significantly higher than the wages other employees in the area are paid for resonably compared work (as compared to the ratio for other hospitals in the same group and their areas).

The committee recognizes that all the data for precise determination of routine operating costs and the labor and nonlabor components of

such costs may not be available from cost reports for accounting years that begin prior to July 1, 1979. To the extent necessary, the Secretary will be expected to make reasonable estimates on the basis of the data available to him.

Hospitals whose actual routine operating costs fell below their target rate would receive one-half of the difference between their costs and their target rate with the bonus payment limited to 5 percent of their target rate. In the first year, hospitals whose actual costs exceeded their target rate, but were no more than 115 percent of that rate, would be paid their actual costs. Those with costs above 115 percent of their target rate would have their reimbursement limited to 115 percent of the target rate.

In the second and subsequent years of the program, the hospital's maximum payment rate would be increased by the actual dollar increase in the average target rate for its group during the preceding year. In calculating the group averages, one-half of costs found excessive would be excluded from the calculation.

Adjustments to a hospital's target rate would be made for (1) changes in the cost of goods and services hospitals purchase; (2) changes in the hospital's classification; and (3) hospitals which manipulate their patient mix or patient flow, reduce services, or have a large proportion of routine nursing services provided by private-duty nurses. Also, a hospital would qualify for any higher target rate that is applicable to the hospitals placed in the bed-size category which contains hospitals closest in bed-size to its actual bed-size.

Exceptions to the target rates would be made for hospitals which demonstrate that their costs exceed their rates because of (1) low utilization justified by unusually high standby costs necessary to meet the needs of a particular area; (2) atypical cost patterns of newly opened hospitals; (3) changed services for such reasons as consolidation, sharing, and approved addition of services among hospitals (e.g., costs associated with low utilization of a new wing); and (4) greater intensity of patient care than other hospitals in the same category. Some hospitals have consistently shorter lengths-of-stay in treating patients than their group average for a reasonably similar mix of patients with comparable diagnoses. To the extent that a hospital can demonstrate that the shorter stays result from an "intensity" of service which makes it necessary for the hospital to incur additional costs, such additional costs per day, to the extent reasonable, should be recognized under the "intensity" exception provision. To the extent not specifically otherwise provided for under the bill, hospital reimbursement would be made by medicare and medicaid subject to and under the provisions of present law.

Hospitals that are dissatisfied with their reimbursement as a result of the operation of the new provisions would be entitled to the same administrative and judicial review as is available under present law.

Health Facilities Costs Commission

On or before January 1, 1979, the Secretary would appoint the members of a new Health Facilities Costs Commission. The Commission would consist of 11 persons who are expert in the health facilities reimbursement area.

The Commission would monitor and study all aspects of the reimbursement system and propose to Congress such changes and refinements as it found feasible and appropriate in the following specific areas:

1. The improvement of the reimbursement reform program; and
2. The possible application (i) of the reimbursement reform program to providers of service other than hospitals, and (ii) of similar classification and comparison techniques to other costs of hospitals and other providers of service.

The Commission would be required to submit an annual report, beginning with 1979, on its activities and any recommended legislative changes.

Hospitals would be exempted from the proposed cost limits if: (a) the hospital is located in a State which has a hospital reimbursement control system which applies at least to the same hospitals and costs as are subject to the new reimbursement reform system; and (b) the State requests use of its own system and demonstrates to the satisfaction of the Secretary that, using the State's system, total medicare and medicaid reimbursable costs for hospitals in the State will be no greater than if the Federal system had been applicable. A State which exceeds, in the aggregate, the costs which would otherwise have been paid under the Federal programs for any two-year period would be covered under the Federal limits beginning with the subsequent year. The amount of the excessive payments would be recouped over subsequent periods through appropriate reduction (not in excess of one percent annually) in the cost limits otherwise applicable.

States which obtain a waiver would be reimbursed for the medicare program's proportionate share of the cost of operating the State reimbursement control system. The State's medicaid program would pay its proportionate share of costs which would be matchable with Federal funds as an administrative expense.

Medicare and medicaid would also pay a proportionate share of startup costs of approved State reimbursement control systems. The Federal share of the startup costs would be the same proportion as the Federal payment for inpatient hospital costs in the State bears to the total inpatient hospital costs which are subject to the State system. For example, if the Federal Government pays, through medicare and medicaid, 40 percent of the total hospital costs in the State that are subject to the State system, it would be liable for 40 percent of the State program's startup costs.

The committee expressed concern over the possibility that the new limits on reimbursement might lead to increased costs for other payors. The new Health Facilities Cost Commission should review the operation of the new medicare-medicaid hospital reimbursement system and report on the extent, if any, to which hospitals bill other payors to cover costs disallowed by medicare and medicaid.

The Commission is expected to also report to the Congress when, in its opinion, a State has, under its approved ratemaking system, established reimbursement under medicare and medicaid at levels so much below what would otherwise be payable in the absence of the State system, as to actually impair the ability of the hospitals to provide necessary care at reasonable cost.

SECTION 8—PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals.

Recent studies have pointed to a national surplus of short-term general hospital beds ranging as high as 100,000 or roughly 10 percent of total available beds. Excess capacity contributes significantly to hospital costs since the initial construction and financing expenses have to be recovered through the hospital charge structure. In addition there are the continuing expenses associated with maintenance and nonpatient services involved in keeping an empty bed ready for use. Surplus beds contribute to cost escalation in other less obvious ways. Unnecessary or underutilized hospital facilities can drain scarce manpower and generate scarcities of trained personnel, which in turn drive up salaries and may even threaten the quality of care. Coupled with the availability of hospitalization insurance, bed surpluses tend to generate pressures to use high cost hospital beds in preference to less expensive alternative forms of care. The development of alternatives to inpatient facilities, such as primary care and community home care programs, suffers when investment is needlessly diverted to underutilized hospital bed capacity. Estimates of the savings that would accrue from closure or conversion of unused or underutilized facilities range from $2 billion to $4 billion annually, depending on whether the change involves closure or conversion of a whole hospital as opposed to a particular service department.

The bill provides for including in hospital reasonable cost payments, reimbursement for capital and increased operating costs associated with the closing down or conversion to approved use of underutilized bed capacity or services in nonprofit short-term hospitals. In the case of for-profit short-term hospitals, reimbursement would be limited to increased operating costs. This would include costs which might not be otherwise reimbursable because of payment "ceilings", severance pay, "mothballing" and related expenses. In addition, payments could be continued for reasonable cost capital allowances in the form of depreciation or interest which would ordinarily be applied toward payment of debt outstanding and incurred in connection with the terminated beds. In the case of complete closing down of a hospital, payments would continue toward repayment of any debt, to the extent previously recognized by the program, and actually outstanding.

The Secretary would establish a Hospital Transitional Allowance Board which shall consider such payments. Appropriate safeguards are to be developed to forestall any abuse or speculation. Prior to January 1, 1982, not more than 50 hospitals could be paid a transitional allowance in order to permit full development of procedures and safeguards. This limited application will also provide Congress with an opportunity to assess the effectiveness and economic effect of this approach in encouraging hospitals to close or modify excess and costly capacity without suffering severe financial penalty.

SECTION 4—FEDERAL PARTICIPATION IN HOSPITAL CAPITAL EXPENDITURES

The bill authorizes certain changes in the current law limitation on medicare and medicaid payments related to hospital capital expenditures in order to require approval of such expenditures as a condition of reimbursement for both capital and direct operating costs. The bill also establishes a special procedure for review and approval of capital expenditures in metropolitan areas involving more than one State or jurisdiction.

Concern over the cost consequences of unnecessary capital investment in hospital facilities has been translated into a variety of legislative and administrative actions at the Federal, State, and local levels. Starting in the mid-sixties, States began enacting legislation requiring the issuance of a certificate of need prior to construction, expansion, modernization, or acquisition of hospital plant or equipment. With the enactment of the Social Security Amendments of 1972, the Federal Government formally adopted the certificate of need concept. Under section 1122 of the Social Security Act, the Secretary is required to seek contract agreements with the States for their review of capital investments in hospital and other health care facilities which exceed $100,000, change the bed capacity, or substantially change the services in the facility. Under such contracts, the Secretary may deny medicare and medicaid reimbursement for depreciation or interest costs if they were incurred without prior State approval.

The bill provides for changes to be made in the current law limitations on medicare and medicaid payments related to hospital capital expenditures. These changes link the procedure directly to the Federal health planning law (Public Law 93–641) and require that the designated planning agency (the State Health Planning and Development Agency as designated under section 1521 of the Public Health Service Act) approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement for both capital and direct operating costs associated with those expenditures. The committee believes that regulations developed by the Department to implement this section should allow for speedy replacement of capital plant and equipment in certain emergency situations.

A special procedure is established for approval of proposed capital expenditures in metropolitan areas which include more than one State or jurisdiction. In such cases the designated planning agencies of all the States or jurisdictions in the area must approve the expenditure, or it would be considered disapproved for purposes of reimbursement, subject to review and reversal by the Secretary.

The bill amends Section 1122(g) of the Social Security Act to clarify that notice, approval and reimbursement penalty requirements contained in that section with respect to approval of health care facility capital expenditures do not apply to simple changes of ownership (either by purchase, or under lease or comparable arrangement) of existing and operational facilities which create no new beds or services.

SECTION 5—AGREEMENTS BY PHYSICIANS TO ACCEPT ASSIGNMENTS

The bill provides incentives for physicians to accept assignment for all their medicare claims. Under the bill there would be "partici-

pating" physicians who voluntarily and by formal agreement agree to accept the medicare reasonable charge determination on an assignment basis as the full billing amount for all services to all medicare patients. Participating physicians would be able to submit claims on alternative simplified bases, including multiple claims forms and would be entitled to administrative cost savings allowances.

Under current law, payments for physicians' services under medicare may be made directly to the beneficiary or to the physician furnishing the service depending upon whether the itemized bill method or assignment method is used when requesting payment from the carrier. An assignment is an agreement between the physician and the medicare beneficiary under which the beneficiary "assigns" to the physician his rights to benefits for covered services included in the claim. In return, the physician must agree to accept the reasonable charge determined by the carrier as his full charge for the items or services rendered. A physician may accept or refuse requests for assignments on a patient-by-patient, bill-by-bill basis.

The committee is concerned that assignment rates have been declining steadily. In calendar year 1977, the assignment rate for physicians other than those who normally bill through a hospital was 50.5 percent. In the case of claims for which assignment is not made, the elderly beneficiary becomes liable for that portion of the physician's charge which is in excess of the reasonable charge determined under the program. In 1977, medicare beneficiaries were responsible for an average charge of $16.54 for each unassigned claim; this was in addition to the required deductible and coinsurance amounts for which they were also liable.

The committee is concerned that the increasing reluctance of physicians to accept assignment has resulted in a severe financial burden for many of the Nation's elderly. It also notes that a number of these individuals are unable to budget for these additional expenses because of uncertainty whether a physician will or will not accept assignment on a particular claim. The committee recognizes that the declining assignment rates are associated with a number of factors including administrative problems, payment delays, increases in the "reasonable charge" reductions, and general attitudes toward the program.

The bill provides incentives for physicians to accept assignments for all their medicare claims. Under the bill there would be "participating" physicians, a concept employed by many Blue Shield plans. A "participating" physician is an M.D. or D.O. who voluntarily agrees to accept the medicare reasonable charge, as payment in full for all services to all his medicare patients. Agreements would be cancellable or concluded on the basis of 30 days' notice. "Nonparticipating" physicians could continue to elect to use the assignment method of billing on a claim-by-claim basis, as under present law.

To expedite payment of claims from participating physicians, the committee bill provides that the Secretary would establish appropriate procedures and forms whereby: (1) such physicians may submit claims on one of various simplified bases and these claims would be given priority handling by the part B carrier; and (2) such physicians may obtain signed forms from their patients making assignment for all services furnished to them and authorizing release of medical information needed to review the claim.

The bill provides for the payment of an "administrative" cost-savings allowance of $1 per eligible patient to a participating physician covering all services included in a multiple billing listing. Two separate allowances would not be made for billing on two listings of items ordinarily included in a single visit or service, nor for different services which were provided to the same patient within a 7-day period. With respect to inpatient or outpatient hospital care, the administrative allowances would be payable only in the case of a surgeon or anesthesiologist, or attending physician or consultant whose principal office and place of practice is outside the hospital, and only where such physicians ordinarily bill and collect directly for their services. No administrative allowance would be payable in the case of claims solely for laboratory tests and X-rays undertaken outside of the office of the billing physician.

The committee expects the revised procedures to improve program efficiency and encourage more physicians to accept assignment. For example, if a physician who does not accept assignments today, and whose routine office visit charge is $10, became a "participating" physician, he would receive an extra $1 allowance for that visit plus probably save at least another $1 in billing, collection and office paperwork costs. In effect, his net practice income from that visit could increase by 20 percent as a result of "participation". The physicians with the lowest charges (often those in rural or ghetto areas) would benefit most from participation, as the cost-savings allowance and the office administrative cost reduction would represent a greater percentage of their charges.

SECTION 6—CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

The bill would permit medicare reimbursement on the basis of an all-inclusive rate to free-standing ambulatory surgical centers and to physicians performing surgery in their offices for a listed group of surgical procedures. Such procedures include those which are often provided on an inpatient hospital basis but can be consistent with sound medical practice, be performed on an ambulatory basis. The rate would encompass reimbursement for the facility, physician and related services, including normal pre- and post-operative visits and routine laboratory and other diagnostic tests usually associated with the procedure.

The list of procedures eligible for such reimbursement would be specified by the Secretary following consultation with the National Professional Standards Review Council and appropriate medical organizations including specialty groups. Subsequently, procedures could be added or deleted as experience dictated.

The committee expects that this provision will encourage performance of surgery in generally lower cost ambulatory settings, where appropriate, instead of the more expensive hospital inpatient setting. It anticipates that States will want to monitor the effectiveness of the new benefit with a view toward making similar modifications in their medicaid programs.

Normal review of such claims by Professional Standards Review Organizations, carriers and other present review mechanisms should

work to safeguard against inappropriate performance of procedures on an ambulatory basis.

Currently, medicare can reimburse the physician for his professional services in any setting. Also, the institutional costs of ambulatory surgery in a hospital outpatient department can be reimbursed. However, a charge for the use of special surgical facilities in a physician's private office or a free-standing surgical facility that is not hospital affiliated is not reimbursable.

Under the bill the physician performing surgery in his office would be compensated for his special, surgical overhead through the all-inclusive rate if he accepts an assignment; there would be no deductible and coinsurance applied in such cases.

Similarly, reimbursement would be provided for the use of the facilities in an ambulatory surgical center, without deductible or coinsurance, where the center accepts assignment. In the case of an ambulatory surgical center, the overhead allowance could be paid directly to the center and the professional fee could be paid directly to the physician. The deductible and coinsurance would be waived for the physician fees for services performed in connection with listed surgical procedures in hospital outpatient departments and other ambulatory surgical centers where the physicians accept assignment.

The overhead factor is expected to be calculated on a prospective basis (and periodically updated) utilizing sample survey and similar techniques to develop reasonable estimated overhead allowances for each of the listed procedures which take account of volume (within reasonable limits). The committee does not intend that an individual physician's financial records be audited in order to determine his specific overhead allowance. Again, what is intended is a reasonable estimate of such costs for physicians generally performing such procedures.

SECTION 7—CRITERIA FOR DETERMINING REASONABLE CHARGE FOR PHYSICIANS' SERVICES

Medicare currently utilizes more than 200 different "localities" throughout the country for purposes of determining part B "reasonable" charges. For example, one State has 28 different localities. The committee notes that this has led in many instances to marked and unjustified disparities in areas of the same State in the prevailing charges for the same service. Additionally, under present law, all prevailing charges are annually adjusted upward to reflect changes in the costs of practice and wage levels. The committee is concerned that the effect of present law is to further widen the dollar gap between prevailing charges in different localities.

The bill provides for the calculation of statewide median charges (in any State with more than one locality) in addition to prevailing charges in the locality. To the extent that any prevailing charge in a locality was more than one-third higher than the statewide median charge for a given service, it would not be automatically increased each year. This provision would not reduce any prevailing charges currently in effect. However, it would operate, to the extent given

charges exceed the statewide average by more than one-third, to preclude automatically increasing those charges.

Under existing law, medicare allows a new doctor to establish his customary charge at not greater than the 50th percentile of prevailing charges in the locality.

The bill would permit new physicians in localities, designated by the Secretary as physician shortage areas, to establish their customary charges at the 75th percentile of prevailing charges (rather than the 50th) as a means of encouraging doctors to move into these communities. It would also permit doctors presently practicing in shortage areas to move up to the 75th percentile on the basis of their actual fee levels.

SECTION 8—PAYMENT FOR CERTAIN ANTIGENS UNDER PART B OF MEDICARE

The bill amends current law to permit payment under medicare for the preparation by an allergist of a reasonable supply of antigens dispensed or administered under the supervision of another physician.

Current medicare law does not permit reimbursement for an antigen prepared by a physician unless he also administers it. However, it is common practice for a doctor to refer a patient to an allergist who prepares a supply of antigens for the referring doctor's use.

SECTION 9—PAYMENT ON BEHALF OF DECEASED INDIVIDUALS

The bill would permit payment by medicare to be made to the spouse or other legal representative of a deceased medicare beneficiary on the basis of a nonreceipted bill for care.

Under present law, medicare can only pay a claim on behalf of a deceased beneficiary where the physician accepts an assignment or where the family has actually paid the bill. The committee notes that in cases where a physician refuses an assignment, families have encountered difficulty in raising sufficient cash to pay the bill in order to be eligible for payment by medicare.

SECTION 10—HOSPITAL PROVIDERS OF LONG-TERM CARE SERVICES

The bill would permit medicare and medicaid reimbursement to small rural hospitals that use the facilities' beds interchangeably as either acute or long-term care beds, depending on need.

Many rural hospitals are the only source of acute care in their communities and as such, are a necessary and vital resource to the people they serve. Although many of these hospitals have recognized that the use of their acute care beds for needed long-term-care services, during periods of excess bed capacity would be desirable, current program participation requirements under medicare and medicaid have discouraged these hospitals from using their empty acute-care beds in this manner.

Under present law, a hospital-based skilled nursing facility can participate in medicare and medicaid only if the facility is a "distinct part" of the institution. To be a distinct-part skilled nursing facility, the facility must be an identifiable, separate unit within the institution.

all beds within the unit must be separated physically from units housing all other patients in the hospital. Various beds scattered throughout the hospital would not comprise a distinct part for purposes of program participation. These distinct-part requirements for hospital-based SNFs were developed primarily to establish a separate cost center for purposes of program reimbursement. However, the requirements have proven to be administratively burdensome and financially detrimental to many small hospitals. In addition, the identification of specific beds, staffing and other program requirements have not allowed sufficient flexibility in meeting episodic demand for acute beds—an important consideration when working with the small total bed complement characteristic of many rural hospitals.

The bill establishes a simplied cost reimbursement formula which would permit small rural hospitals to avoid the requirement for separate patient placement within the facility and separate cost finding. However, hospitals qualifying for such reimbursement are not prohibited from physically separating their long term and acute case patients.

Reimbursement for routine SNF services under medicare would be at the average rate per patient-day paid for routine services during the previous calendar year under medicaid to SNFs located in the State in which the hospital is located. Reimbursement under medicaid would be at the rate paid to SNFs and ICFs in the previous year. Reimbursement for ancillary services would be determined in the same manner as under present law.

Reimbursement under the new formula would be allowed in a hospital which (1) has less than 50 beds; (2) is located in a rural area; and (3) has been granted a certificate of need for the provision of long-term-care services.

In setting these qualifications, the committee concluded that, since the general staffing pattern in small rural hospitals is relatively fixed due to minimum staffing requirements, there should be opportunities for providing needed long-term-care services at very little additional cost.

The committee would emphasize that the reimbursement method authorized by this section of the bill is optional and hospitals may continue to elect to establish distinct part SNFs as provided for under existing law. In addition, it is not the intention of the committee that this provision prohibit States from continuing to use other approved reimbursement methods under State medicaid plans.

The bill provides, that within 3 years after enactment, the Secretary shall report to Congress concerning whether a similar provision should be extended to other hospitals where there is a shortage of long-term-care beds, regardless of number of beds or geographic location.

SECTION 11—REIMBURSEMENT RATES UNDER MEDICAID FOR SKILLED NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES

The bill allows States the option, when computing reimbursement rates under medicaid to a SNF or ICF, to include reasonable allowances for the facility in the form of incentive payments related to efficient performance.

Present law requires States participating in medicaid to pay SNFs and ICFs on a reasonable cost-related basis. This requirement, added by section 249 of the Social Security Amendments of 1972, gives States the option of using medicare's reasonable cost reimbursement formula for purposes of reimbursing SNFs and ICFs or developing other reasonable cost-related methods of reimbursement acceptable to the Secretary.

There has been considerable controversy over whether the reimbursement mechanisms developed under section 249 may include an allowance in the form of incentive payments related to efficient performances by providers.

The committee, during consideration of section 249, did not intend to preclude such allowances if they are related to efficient provider performance. It has therefore, added this clarifying provision to existing law to insure that States have the option to include incentive allowances related to efficient performance in reimbursement formulas under section 249 of Public Law 92–603.

SECTION 12—MEDICAID CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

The bill provides that final determinations of basic eligibility of skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) under medicaid be made by the Secretary.

Under present law the State medicaid agency makes the decision as to whether a SNF or ICF applying to participate in the medicaid program only is qualified to participate in the program.

However, for a SNF participating in medicare only, or both medicare and medicaid, the Secretary makes the decision as to whether the facility is qualified to participate in the programs.

The committee believes that the State certification of SNFs and ICFs results in lack of uniformity in the application of the Federal standards to which all such facilities are subject.

The bill would establish a uniform health care facility certification process for medicare and medicaid long term care facilities. As under present law, the appropriate State health agency would survey facilities wishing to participate in either (or both) medicare or medicaid. The bill provides, however, that the Secretary make a determination as to eligibility and advise the State if a facility meets the basic requirements for participation as a medicaid SNF or ICF. The Secretary would specify the length of time (not to exceed 12 months) for which approval could be granted.

The State could accept as a participant in the medicaid program any facility certified by the Secretary. A State could not receive Federal matching funds for services provided by any facility not approved by the Secretary.

Facilities dissatisfied with the findings of the Secretary would be entitled to a hearing by the Secretary and to judicial review of the Secretary's final decision following the hearing.

The purpose of the provision is to assure more uniform application of health and safety standards and timely termination of facilities with serious deficiencies.

SECTION 13—VISITS AWAY FROM INSTITUTION BY PATIENTS OF SKILLED NURSING OR INTERMEDIATE CARE FACILITIES

The bill prohibits the Secretary of HEW from imposing numerical limits in the number of home visits which might be made by SNF or ICF patients under the medicaid program.

Until recently, HEW policy has limited Federal payments for the cost of reserving beds in skilled nursing facilities (SNFs) and intermediate care facilities (ICFs) for medicaid patients temporarily away from the institution. The regulations permitted Federal funds to be used to reserve a bed for 15 days each time a patient was in a hospital for acute care. They also permitted Federal contributions for a total of 18 days during a 12-month period when patients were visiting their homes or other places for therapeutic reasons.

Last year, the Health Care Financing Administration amended the regulations to remove all limitations on Federal funding of therapeutic absences as long as they are authorized and provided for in the patients' plan of care. Currently, however, there are no requirements in existing law setting forth policies with respect to reserving beds in SNFs and ICFs for medicaid patients who are temporarily away from the institution.

The bill provides that visits outside of the SNF or ICF would not necessarily constitute conclusive proof that the individual is no longer in need of the services of the SNF or ICF. However, the length and frequency of visits must be considered, together with other evidence, when determining whether the individual is in need of the facility's services. The provision thus prohibits the Secretary from imposing numerical limits on the number of home visits which might be made by SNF or ICF patients. The committee believes that such matters should be left to professional medical judgment.

SECTION 14—NOTIFICATION TO STATE OFFICIALS

The bill provides, under certain circumstances, for notification of the Governor and appropriate committee chairmen in a State legislature of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments affecting programs authorized under the Social Security Act.

The committee has become aware of instances where the Governors and chairmen of the appropriate legislative and appropriation committees in State legislatures have not been informed on a timely basis of deficiencies or potential compliance issues involving Federal-State programs authorized under the Social Security Act.

The committee bill provides that if the Secretary notifies a State of any audits, quality control performance reports, deficiencies, or changes in Federal matching payments under programs authorized under the act, simultaneous notification would also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the affected program.

SECTION 15—REPEAL OF SECTION 1867

The bill terminates the Health Insurance Benefits Advisory Council.

The original 1965 medicare legislation provided for the establishment of the Health Insurance Benefits Advisory Council (HIBAC) under the new section 1867 of the act. This Council was to provide advice to the Secretary on matters of general policy with respect to the administration of medicare. The Social Security Amendments of 1972 modified the role of the Advisory Council so that its function would be that of offering suggestions for the consideration of the Secretary on matters of general policy in both the medicare and medicaid programs.

In view of the establishment of other advisory groups, and the Secretary's authority to establish ad hoc advisory bodies, the bill would terminate HIBAC.

SECTION 16—PROCEDURE FOR DETERMINING REASONABLE COST AND REASONABLE CHARGE

The bill provides, except under certain specified circumstances, that reimbursement to contractors, employees or related organizations, consultants, or subcontractors at any tier would not be recognized where compensation or payments (in whole or part, in cash or kind) are based upon percentage arrangements.

Such arrangements can take several forms. For example, some involve business contracts for such support services as computer and data processing, financial and management consulting, or the furnishing of equipment and supplies to providers of health services, such as hospitals. Charges for such services are subsequently incorporated into the cost base against which medicare and medicaid make their payment determinations.

The contracts for these support services specify that the remuneration to the suppliers of the services shall be based on a percentage of the gross or net billings of the health care facilities or of individual departments. Other examples involve landlords receiving a percentage of provider gross (or net) income in return for office space, equipment, shared waiting rooms, laboratory services, custodial and office help and administrative services. Such arrangements can be highly inflationary and add costs to the programs which may not reflect actual efforts expended or costs incurred.

The prohibition against percentage arrangements contained in this section of the bill would include payment of commissions and/or finders' fees and lease or rental arrangements on a percentage basis. It would also apply to management or other service contracts or provision of services by collateral suppliers such as pharmacies, laboratories, etc. The percentage prohibition would flow both ways either from the supplier or service agency back to the provider or organization, or from the original provider or organization to the supplier or service agency.

The committee does not, however, intend this provision to interfere with certain types of percentage arrangements which are customarily considered normal commercial business practices such as the Commission paid to a salesman. Further, the bill does not prohibit reimbursement for certain percentage arrangements such as a facility management contract where the arrangement contributes to efficient and economical operation.

For example, under some existing management contracts, the contractor receives both a percentage of operating expenses as a base management fee, and a share of the net revenues of the institution after all costs have been met. Where the contractor's percentage share of net revenues exceeds the percentage on which the base management fee is calculated, the contractor could have a strong incentive to contain operating expenses. Of course, under such circumstances, the reasonableness of the percentages applicable to the operating expenses would have to be considered in terms of comparison with the costs incurred in the management and/or operation of reasonably comparable facilities which do not utilize such contracts.

SECTION 17—AMBULANCE SERVICE

The bill provides for medicare reimbursement for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care.

Under present law, medicare will pay for ambulance services to the nearest participating institution with appropriate facilities where the use of other means of transportation is contraindicated by the individual's condition. The term "appropriate facilities" means that the institution is generally equipped to provide the needed hospital or skilled nursing care for the illness or injury involved. The individual physician who practices in a hospital is not a consideration.

Occasionally, the nearest hospital with appropriate facilities does not have a physician available to undertake the required specialized care. The present alternatives are to bring the physician to the patient—a possible misuse of physician time—or to transport the patient to the more distinct facility at his own expense.

The committee also notes that in some areas of the country, particularly rural areas, radiation for cancer therapy is provided by radiation clinics rather than in a hospital. In these areas patients who require transportation by ambulance—where other forms of transportation are medically contraindicated—to a radiation clinic cannot qualify for medicare reimbursement.

The bill provides medicare reimbursement for ambulance services to a more distant hospital when the nearest hospital does not have staff qualified to undertake the required care. The committee intends that the ambulance benefit also be extended to cover patients who require ambulance transportation to receive radiation therapy in clinics in areas where the treatment is not available in a hospital.

SECTION 18—GRANTS TO REGIONAL PEDIATRIC PULMONARY CENTERS

This section of the bill is identical (except for effective dates) to an amendment approved by the Senate in 1972.

The bill authorizes up to $5 million annually for grants to public or nonprofit private regional pediatric pulmonary centers which are part of (or affiliated with) institutions of higher learning. These grants are to assist institutions in the training of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases and providing needed services for children and young adults suffering from such diseases.

SECTION 19—WAIVER OF HUMAN EXPERIMENTATION PROVISION FOR MEDICARE AND MEDICAID

The bill waives requirements of the human experimentation statute which may otherwise be held applicable for purposes of medicare and medicaid. For example, the bill waives such requirements with respect to coverage, or copayment, deductibles, or other limitations on payment for services.

Under current law, State medicaid programs may impose nominal cost-sharing requirements on medicaid eligibles. Recently, a State's cost-sharing experiment was challenged as a violation of regulations implementing the human experimentation statute. The challenge would effectively prevent any cost-sharing experiments under the medicaid program, and could seriously hinder other medicaid and medicare cost control efforts.

The committee intends that this provision exempt medicare and medicaid with respect to reimbursement or administrative activities (not designed to directly experiment with the actual diagnosis or treatment of patients) from the requirements of title II of Public Law 93–348.

SECTION 20—DISCLOSURE OF AGGREGATE PAYMENTS TO PHYSICIANS

The bill prohibits the Secretary from routinely releasing medicare information, and provides that State agencies shall not be required to release medicaid information, relating amounts paid to physicians under the respective programs, except as otherwise specifically required by Federal law.

Recent disclosures of physicians receiving large payments under medicare have served unjustifiably to embarrass physicians who serve a large number of elderly patients. The disclosures have also been characterized by a high degree of inaccuracy which has unfairly embarrassed some physicians.

SECTION 21—RESOURCES OF MEDICAID APPLICANT TO INCLUDE ASSETS DISPOSED OF AT SUBSTANTIALLY LESS THAN FAIR MARKET VALUE

The bill requires States to deny medicaid eligibility in cases where an otherwise ineligible aged, blind, or disabled person disposes of significant assets by either giving them away or selling them for less than fair market value in order to establish medicaid eligibility.

Under present law, States which use the SSI criteria in determining medicaid eligibility for the aged, blind, and disabled may not impose transfer of assets restrictions on those applicants. Thus, an applicant who wants medicaid coverage can transfer assets which could be applied to the cost of medicaid-financed services and immediately become eligible for medicaid. This situation damages program credibility by allowing relatively well off individuals to become eligible for medicaid. It also increases program costs, especially for expenditures for institutional care. The aged, blind, and disabled account for some 64 percent of all program expenditures. They are most likely

to need hospital, skilled nursing, and intermediate care facility services which comprise two-thirds of medicaid benefit costs.

Some 25 to 30 States are currently imposing restrictions on the transfer of assets on some medicaid groups but not on others. Title IV–A of the act does not prohibit such State eligibility conditions. Further, those States which choose to use the more restrictive standards for medicaid eligibility for the aged, blind, and disabled rather than the SSI criteria can impose this eligibility condition if they did so in January 1972.

The only way a State can impose restrictions on asset transfers by SSI recipients is to use the more restrictive standards of medicaid eligibility for the aged, blind and disabled permitted under section 1902(f) of the Social Security Act. However, most States do not choose this option because they either contract with the Secretary (the Social Security Administration) under section 1634 of the Social Security Act to do medicaid eligibility determinations of SSI recipients, or rely on the SSI eligibility lists transmitted from the Social Security Administration for making their own medicaid eligibility determinations.

The bill requires States to deny eligibility for medicaid in cases where an otherwise eligible aged, blind, or disabled person disposes of significant assets by giving them away or selling them for substantially less than their fair market value in order to establish medicaid eligibility. Any such transaction will be presumed to be for the purpose of establishing medicaid eligibility unless and until the individual submits adequate evidence to rebut that persumption. States may be allowed some flexibility with regard to procedures which demonstrably are not cost/beneficial, but States will be required to make a good-faith effort to enforce this requirement. Where a State finds that a disposal of assets has occurred, the difference between the fair market value of the asset and the actual amount the individual received for it will continue to be considered as his asset for purposes of medicaid eligibility for a period of 12 months.

The committee intends that this authority would be administered by the States even though other elements of medicaid eligibility may be determined by the Social Security Administration under the agreements entered into pursuant to section 1634 of the Social Security Act. It is expected, however, that the Social Security Administration would agree to reasonable State requests for referral of SSI applicants to appropriate State or county agencies for determination of this additional eligibility factor.

The committee wishes to emphasize that the provision is aimed at abusive situations where assets are sold for substantially less than their fair market value. It is not intended, for example, that the provision would be used to call into question the sale of a piece of land for $1,000 or $2,000 in which the sale price may fall short of the agency's estimate of fair market value by $100 or $200.

SECTION 22—RATE OF RETURN ON NET EQUITY FOR FOR-PROFIT HOSPITALS

The bill changes the allowed rate of return on for-profit hospitals' net equity, which under present law is equal to 1½ times the current

rate of return on social security trust funds. The new rate of return multiplier would be: 2½ times for hospitals entitled to an incentive payment under the incentive reimbursement system in section 2 of the bill; 2 times for hospitals that are reimbursed only their reasonable costs; and 1½ times for hospitals with costs in excess of their routine cost limits. The new rates of return would become effective at the same time as the new incentive reimbursement system—i.e., July 1, 1979.

The committee also anticipates that at such time as skilled nursing facilities are reimbursed under an appropriate system of classification and comparison and made subject to incentives and penalties, returns on equity similar to those established by this section for hospitals would be made applicable to such facilities.

SECTION 23—DEDUCTIBLE NOT APPLICABLE TO EXPENSES FOR CERTAIN INDEPENDENT LABORATORY TESTS

The bill waives the $60 deductible in applying special laboratory billing procedures under medicare.

Legislation developed by the committee and enacted in 1972 (section 279 of Public Law 92–603) was designed to avoid the unreasonably high administrative costs that independent laboratories and the medicare program incur in the billing and processing of typically inexpensive diagnostic tests. That provision was intended to reduce these billing and processing costs by authorizing the Secretary of HEW to negotiate payment rates with individual laboratories which medicare would pay in full, without any need for the laboratory to bill the patient for the $60 deductible and 20 percent copayment amounts. The negotiated rates could be no higher than medicare would have paid in the absence of the new provision.

The new billing procedure was never utilized because, as a result of a drafting error, the $60 deductible was retained. Thus, since laboratories still have to bill patients for deductible amounts, and since medicare must still determine each patient's deductible status, the savings to laboratories and medicare cannot now be achieved.

The bill waives the $60 deductible in applying the special laboratory billing procedure, as was intended by section 279 of Public Law 92–603.

SECTION 24—PAYMENT FOR LABORATORY SERVICES UNDER MEDICAID

The bill allows a State to purchase laboratory services for its medicaid population through competitive bidding arrangements for a 3-year experimental period.

The committee notes that the Comptroller General, in a July 1, 1978, report to the Congress, recommended that States be given greater latitude in paying for independent laboratory services under medicaid. States have been restrained in adopting cost-saving contract bidding and negotiated rates with laboratories by an interpretation of the present "freedom of choice" provision. That provision, a Finance Committee amendment in 1967, was intended to permit medicaid recipients to choose from among any qualified doctors, drugstores, etc. It was not intended to apply to the types of care or services, such as laboratory services, which the patient ordinarily does not choose.

The committee bill allows a State to purchase laboratory services for its medicaid population through competitive bidding arrangements for a 3-year experimental period. Under this provision, services may be purchased only: (1) from laboratories meeting appropriate health and safety standards; (2) no more than 75 percent of the charges for such services are for services provided to medicare and medicaid patients; and (3) only if the laboratories charge the medicaid program at rates that do not exceed the lowest amount charged to others for similar tests. The bill would also make conforming changes in title XIX to provide that medicaid payments generally may be made only to clinical laboratories meeting applicable standards.

SECTION 25—STATUS OF PROFESSIONAL REVIEW ORGANIZATIONS

The bill clarifies that professional standards review organizations (PSRO's) are not to be considered Federal agencies for purposes of public disclosure of information developed or compiled in accordance with their responsibilities under the Social Security Act.

The committee is concerned over a decision of the U.S. District Court for the District of Columbia on April 25, 1978, which held that a PSRO is an "agency" of the Federal Government for purposes of the Freedom of Information Act (FOIA) and is thus subject to its disclosure requirements. This decision, which is currently being appealed, means that the data and information in control of the PSRO must be disclosed, on request, unless the particular information can be protected under one of the various exceptions to that act.

One of the underlying tenets of the PSRO program is that local medical professionals are best able to review the quality and appropriateness of medical care. The District of Columbia's District Court's conclusion that PSRO's are subject to FOIA is clearly inconsistent with congressional intent. The decision would also effectively supplant the Social Security Act's directive to HEW to develop specific regulations governing the disclosure of information acquired by PSRO's.

While the committee recognizes that the recent court action is being appealed, it feels that it is important to move promptly to clarify PSRO's status with respect to the Freedom of Information Act. The committee views with concern the detrimental impact on the developing PSRO program which would result if these organizations were subject to the broad requirements of FOIA. PSRO's rely on voluntary service by local physicians. Should all data acquired by PRSO's be disseminated without safeguards, recruitment of physicians to perform PSRO functions would become increasingly difficult. Moreover, the intent of peer review, as opposed to Government regulation, is to allow the profession to attempt to regulate itself with some degree of privacy and candor. In addition, subjecting PSRO's to FOIA would result in increased administrative burdens, large additional expenses for the defense of lawsuits, and great uncertainty and delay in the performance of PSRO functions.

The committee notes that section 1166 of the Social Security Act sets forth principles on the basis of which HEW is to promulgate regulations governing both disclosure and confidentiality of information acquired by PSRO's in the exercise of their duties. This section

specifies that information may be disclosed to the extent necessary to carry out program purposes, to assist with the identification of fraudulent and abusive activities, and to assist in the conduct of health planning activities. Provision is made for the confidentiality of individual patient medical records. The committee is convinced that the provisions of section 1166 are a more appropriate approach to the difficult disclosure issues surrounding PSRO's than wholesale application of FOIA.

Further, the Secretary of HEW in his regular review of PSRO performance can, under present law, evaluate the review activities—including practitioner profiles of practice—and thus safeguard against any general indiscriminate or willful action or inaction by a given PSRO with respect to practitioners.

The committee bill therefore clarifies that no PSRO or statewide PSR council shall be considered an agency or authority of the Federal Government for purposes of public disclosure of information developed or collected in carrying out the functions of the act.

Provisions of Public Law 95–142 provide for exchange by PSRO's and other entities of objective data such as statistical and aggregate information. Those provisions are not affected by the committee amendment.

SECTION 26—REPEAL OF 3-DAY HOSPITALIZATION REQUIREMENT AND 100-VISIT LIMITATION FOR HOME HEALTH SERVICES

The bill removes the provision in existing law that limits medicare home health benefits to 100 visits per spell of illness under part A and 100 visits per year under part B. In addition, the bill removes the requirement that a beneficiary has to be an inpatient in a hospital for at least 3 days before he can qualify for part A home health benefits.

Under present law, a beneficiary is eligible for 100 home health visits per spell of illness under part A of medicare following an inpatient stay in a hospital of at least 3 days. Beneficiaries are also eligible for 100 home health visits per calendar year under part B of medicare whether or not they had been hospitalized previously. By removing the numerical limit on home health visits and the 3-day prior hospitalization requirement, the committee believes that the home health benefit will become more widely available to eligible persons in need of such care.

SECTION 27—PAYMENT FOR DURABLE MEDICAL EQUIPMENT

Under the medicare law, reimbursement for the rental or purchase of durable medical equipment is based largely on the supplier's customary charge for the item and on the prevailing charge for the equipment in the locality. Medicare has experienced problems with this method of reimbursement because of the lack of uniformity in suppliers' billing and charging practices; differences in the level of services offered by different suppliers; the different approaches medicare carriers follow in calculating allowances for medical equipment; and because equipment charges are not set in a broadly competitive marketplace.

The bill establishes a new reimbursement methodology for medical equipment intended to correct these problems. Under the new method, reasonable charges for durable medical equipment would be calculated on a prospective basis and would take into account, in addition to the customary and prevailing charges, the acquisition costs of the equipment, appropriate overhead (considering the level of delivery services and other necessary services provided by the supplier), and a reasonable margin of profit.

An additional problem has arisen as a result of the provision of present law which authorizes lump-sum payments by medicare for durable medical equipment where purchase would be more economical than rental. In these cases the patient is responsible for paying (in addition to any deductible and coinsurance amounts) any difference between the supplier's charge for the item and the medicare allowable charge. This difference can be substantial since the medicare allowable charge is based on charge levels as they existed from 12 to 24 months in the past. The bill would eliminate this lag where the medicare allowable charge is calculated in accordance with the new methodology by permitting the allowable charges to be calculated (no less often than annually) on a prospective basis.

The committee recognizes that the proposed new methodology represents a significant departure and that its full implementation will necessarily take place over a period of many months and only after consultation with durable medical equipment suppliers generally representative of various kinds of organizations in the industry. In the interim, the committee expects HEW to avoid major policy changes in the application of the customary and prevailing charge criteria which might seriously disrupt the industry. There is widespread concern among suppliers that medicare has proposals under consideration which would reduce allowable charges without consideration of the extraordinary expenses which some dealers incur. For example, some suppliers explain that they deliver items to remote areas not serviced by dealers who have lower charges. Some spend time assisting elderly customers by explaining how to use their equipment properly and safely and by helping to assemble it where lower cost dealers only deliver the equipment. Of course, while it would seem appropriate to recognize necessary additional expenses that some dealers may have to bear because of the special needs of their customers, it is intended that there be a rollback of allowable charges where they are found clearly and significantly excessive.

SECTION 28—DEVELOPMENT OF UNIFORM CLAIMS FORMS FOR USE UNDER HEALTH CARE PROGRAMS

The committee bill requires HEW to adopt, to the extent feasible, standardized claims forms for medicare and medicaid within 2 years of enactment. Such forms could vary in a given State for medicaid if the Secretary determined that, in that State, a uniform national medicare-medicaid claims forms could not be utilized.

The committee notes with concern that the medicare and medicaid programs have added to the paperwork required of physicians, hospitals, skilled nursing facilities, and other health care organizations as

a result of the proliferation of forms. For several years, HEW has been working to develop standardized claims forms that might be used by physicians and institutions in billing both medicare and medicaid. This effort has been carried out in conjunction with provider groups, including the American Medical Association, the American Hospital Association, and the American Dental Association. The National Association of Blue Cross-Blue Shield Plans and the Health Insurance Association of America also participated. Standardized physician benefit forms now have been developed and are being used by medicare, medicaid and Blue Shield in several States. A promising uniform hospital benefit form has also been developed.

The committee bill requires the Secretary, within 2 years of enactment, to develop and require to be employed to the extent feasible, uniform claims forms that would be utilized in making payment for health services under medicare and medicaid. Such claims forms may vary in form and content but only to the extent clearly required. The Secretary would be required to use the claims forms developed for purposes of medicare and medicaid for other programs over which he has administrative responsibility if he determines that such use is in the interest of effective administration of such programs.

The committee bill requires the Secretary, in carrying out the requirements of this section, to consult with those charged with the administration of other Federal health care programs, with other organizations that pay for health care, and with providers of health services to facilitate and encourage maximum use by other programs of the uniform claims forms. The bill further requires the Secretary to report to the Congress within 21 months of enactment on: (1) what actions he will take pursuant to this section; (2) the degree of success in encouraging third parties generally to adopt uniform claims forms, and (3) his recommendations for legislative and other changes needed to maximize the use of such forms.

SECTION 29—COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

The bill provides for the use of medicare audit findings in the administration of medicaid and the maternal and child health program.

The committee has been concerned that the duplication of identical or similar auditing procedures used for the purpose of determining reimbursement under various Federal health benefit programs is costly to both the programs and the entity (such as a hospital, skilled nursing facility, or home health agency) participating in the program.

The committee bill therefore requires that, if an entity provides services reimbursable on a cost-related basis under title XVIII and titles XIX or V, audits of books, accounts, and records of that entity for purposes of the State programs are to be coordinated through common audit procedures with audits performed for the purposes of reimbursement under title XVIII. Where a State declines to participate in such common audits, the Secretary is to reduce payments that would have been made to the State under titles V or XIX by the amount attributable to the duplicative State audit activity. A State participating in the common audit procedure would continue to receive Federal matching for administrative costs associated with any additional or supple-

mental audit data or audits that may be necessary under their medicaid and maternal and child health programs. The committee expects that audits under title XVIII will be carried out in timely fashion in order to expedite the interprogram coordination.

SECTION 30—ENCOURAGEMENT FOR HEALTH CARE OF PHILANTHROPIC SUPPORT

Under present medicare policy, in determining the reasonable costs of services furnished by a provider of health services, unrestricted grants, gifts and income from endowments are not deducted from reimbursable costs of the provider. The bill provides a statutory base for this policy.

In addition, the committee encourages States, when developing their hospital ratemaking programs, to treat unrestricted gifts, grants and income from endowments in the same fashion as under medicare and medicaid.

SECTION 31—PARTICIPATION UNDER MEDICARE AND MEDICAID BY SKILLED NURSING FACILITIES

The bill would require skilled nursing facilities (SNFs) to participate in both medicare and medicaid as a condition to their participation in either program.

Under current law, SNFs participating in one of the programs are not required to participate in the other. It has come to the committee's attention that in some States, there are a larger number of medicaid-only participating SNFs and in other States, the reverse is true. By requiring SNFs to participate in both programs, it is anticipated that a more adequate number of skilled nursing facilities will be available for both medicare and medicaid beneficiaries.

The Secretary of HEW is expected to monitor closely the effects of implementation of this provision and to advise the Congress of any unintended or unanticipated consequences.

The committee also expects that HEW will act immediately to implement that provision of the 1972 Social Security amendments (sec. 249 of Public Law 92–603) which authorizes simplified reimbursement for SNF care under medicare. That provision authorizes medicare payment based upon a percentage above a State's medicaid payment rate where the Secretary has found the medicaid payment methodology reasonable. Simple comparison of the present medicare payments to SNFs in a State under the detailed medicare cost finding procedures with what would be payable under the section 249 approach should serve as a reasonable test of the economy of the simplified method. This test would not be routinely undertaken as a duplicative effort but solely for purposes of determining whether to proceed.

SECTION 32—COVERAGE UNDER MEDICARE OF CERTAIN DENTISTS' SERVICES

The bill extends the coverage of dental services under medicare to include any services performed by a doctor of dental surgery or of dental medicine which he is legally authorized to perform in cases where the services would be covered if performed by a physician.

Under present law, medicare covers the services of dentists when they are performed by a licensed doctor of dental or oral surgery only with respect to (1) surgery related to the jaw or any structure contiguous to the jaw, or (2) the reduction of any fracture of the jaw or any facial bone. The law, therefore, excludes from coverage certain nonsurgical procedures which dentists and oral surgeons are professionally trained and licensed to perform even though the same services are covered when performed by a physician.

The committee is also concerned about the present medicare policies concerning payment for inpatient hospital services provided in connection with the performance of excluded dental services.

Under present law, the inpatient hospital services can be covered where the patient, because of his underlying medical condition and clinical status, requires hospitalization in connection with the provision of these dental services which are not themselves reimbursable. The committee notes that there is a considerable body of authoritative medical opinion which supports the conclusion that many relatively healthy, aged individuals should have available the sophistication and immediacy of a hospital inpatient level of care when undergoing extensive and serious dental services, e.g., full mouth extractions, although they do not exhibit observable signs of underlying illness. The committee does not believe that it should be necessary that the underlying medical condition, per se, require hospital admission to receive a covered inpatient level of care but rather that hospitalization should be necessary to monitor and, if necessary, to treat the patient's underlying medical nondental condition. It must be documented by medical evidence that a reasonable probability, as opposed to a mere possibility, exists that such monitoring on an inpatient basis is warranted. The patient's medical history, current medical status and the nature of the dental condition and treatment must be taken into account, as well as any medications the patient may be taking.

While the aging process of course contributes to the likelihood of an underlying medical condition and advanced age thus warrants consideration in a determination of coverage for the inpatient stay, age by itself would not constitute an underlying medical condition for purposes of this requirement. The inpatient services must be justified on the basis of the underlying medical (nondental) condition and not on the severity or the complexity of the patient's dental problem alone.

SECTION 33—COVERAGE UNDER MEDICARE OF OPTOMETRISTS' SERVICES WITH RESPECT TO APHAKIA

The bill authorizes medicare part B reimbursement to optometrists for covered services related to aphakia which are within the scope of licensed optometric practice.

Current medicare law provides reimbursement for diagnosis and treatment of the diseases of the eye when such services are provided by physicians. Certain diseases of the eye result in surgical removal of the lens. The resulting condition, i.e., absence of the lens of the eye, is known as aphakia. Eyeglasses (or contact lenses) which serve as the prosthetic lens for aphakia are covered under the program. In addition to physicians, optometrists are reimbursed under the program for

services to aphakic patients. These reimbursable services are limited, however, to dispensing services in connection with the actual fitting and provision of prosthetic lenses. Section 109 of Public Law 94–182 required HEW to conduct a study concerning the appropriateness of medicare reimbursement of services performed (but not presently reimbursed) by optometrists in providing prosthetic lenses for patients with aphakia. In a report transmitted to the Congress on January 12, 1977, HEW recommended that those covered services related to aphakia and within the scope of optometric practice be reimbursable under part B of medicare when provided by optometrists. The committee bill incorporates this recommendation.

The committee noted that HEW report recommended further study prior to any additional extention of Part B coverage of optometric services. The committee expects that HEW will complete such study and report to the Congress within 12 months after enactment of the bill.

SECTION 34—RENEWAL OF BENEFITS

Under present law, a beneficiary must remain, for 60 consecutive days, out of an institution which is determined to be primarily engaged in providing skilled nursing care and related services in order to renew his medicare eligibility for additional days of hospital and skilled nursing facility benefits. Regulations of the Secretary establish the criteria which define the institutions where patients cannot renew benefit eligibility. In general these institutions consist of: all skilled nursing facilities which participate in medicare and medicaid, some of the intermediate-care facilities that participate in medicaid, and additional nursing care institutions that participate in neither program. The intent of the provision was to permit beneficiaries to renew their benefit eligibility once they have ended a spell of illness (and, thus, for at least 60 days, no longer needed skilled nursing).

The committee is concerned about the frequency with which beneficiaries in skilled nursing institutions who have exhausted their benefits are prevented from renewing their eligibility even though they actually receive little or no skilled care. This is especially a problem in States which require the availability of nurses in institutions that are largely for patients who do not need skilled nursing.

The committee bill directs the Secretary to review current procedures for applying the benefit-renewal criteria to make sure that they are not too restrictive. The Secretary would report his findings and conclusions to the Congress within 9 months of enactment, together with any legislative recommendations he may wish to propose.

SECTION 35—STATE MEDICARE "BUY-IN"

The medicare law gave States until January 1, 1970, to request enrollment of their public assistance beneficiaries in part B of the medicare program. States that entered into these so-called "buy-in" agreements pay the part B premiums for the public assistance enrollees. The "buy-in" provision was designed to encourage the highest possible participation of the elderly in the part B program. Alaska, Louisiana, Oregon, Puerto Rico, and Wyoming did not make timely ar-

rangements to enroll their public assistance beneficiaries in the part B program.

The committee amendment would give the States that wish to do so an additional period of 12 months in which they could elect to make the necessary coverage arrangements.

III. Budgetary Impact of the Bill

In compliance with section 252(a) of the Legislative Reorganization Act of 1970 and sections 308 and 403 of the Congressional Budget Act of 1974, the following statements are made concerning the budgetary impact of the bill. The bill is consistent with the allocation report of the committee for fiscal year 1979 (Senate Report 95–950). The estimate of the costs of the bill prepared by the Congressional Budget Office appears below. The committee accepts the estimates provided by CBO

Reductions in Federal expenditures beyond those included in the CBO estimate may well be anticipated even though the committee is not prepared to venture specific estimates at this time. For example, the reductions projected under Section 2 of the bill relate only to hospital routine costs. It is reasonable to anticipate that within 2 or 3 years of enactment, procedures for moderating hospital ancillary costs will also be incorporated into the program—with additional savings.

As CBO noted, its estimate of savings under section 2 does not allow for changes in hospital behavior. To the extent that hospitals with excessive costs moderate their spending to bring it in line with reimbursement, to the extent that other hospitals moderate their spending patterns to avoid being penalized or to move into a position where they would be eligible for incentive payments, the average per diem cost, calculated annually, would not rise as rapidly as reflected in the CBO assumption. That positive effect would work to further reduce medicare and medicaid spending significantly.

The full impact of the section encouraging surgery, where appropriate, on an ambulatory basis—rather than in-hospital—cannot be gauged at this time; reductions in expenditures significantly greater than those indicated by the CBO estimate may well be realized.

U.S. Congress,
Congressional Budget Office,
Washington, D.C., August 9, 1978.

Hon. Russell B. Long,
Chairman, Committee on Finance,
U.S. Senate, Washington, D.C.

Dear Mr. Chairman: Pursuant to section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for S. 1470, the Medicare-Medicaid Administrative and Reimbursement Reform Act.

Should the committee so desire, we would be pleased to provide further details on the attached cost estimate.

Sincerely,

Alice M. Rivlin, *Director.*

August 10, 1978.

1. Bill No. S. 1470.

2. Bill title: Medicare-Medicaid Administrative and Reimbursement Reform Act

3. Bill status: As ordered reported by the Committee on Finance on August 3, 1978

4. Bill purpose: To amend the Social Security Act and to provide for reform of procedures currently employed under the medicare and medicaid programs.

In the area of hospital reimbursement, section 2 of the bill establishes a new method of reimbursing routine operating costs for hospitals under the medicare and medicaid programs. Routine costs greater than 115 percent of the average for similar hospitals would not be reimbursed. This upper limit would be lowered relative to the average each year. Hospitals with costs below the average would receive bonus payments. Section 2 also establishes a Health Facilities Cost Commission and provides funds for state cost containment commissions which cover medicare and medicaid hospital costs. Section 3 provides for incentive payments to be made to hospitals that close, or convert to alternative use, facilities that are underutilized. Under section 4, changes are made in the current law limitations on medicare and medicaid payments related to hospital capital expenditures.

The bill includes several changes in reimbursement procedures affecting health care practitioners. Section 5 provides for speedier bill processing and an administrative cost-saving payment of $1 per claim for physicians who agree to accept assignment. Under section 6, physicians performing surgery in their offices would be compensated for their special surgical overhead through all-inclusive, prospectively established rates, provided that they accept assignment. Section 7 changes the criteria for determining reasonable charges for physicians' fees by limiting the difference between the highest local fee and the statewide median fee for a procedure to one-third of the statewide median. The section also allows physicians practicing in physician-shortage areas to establish their fees at the 75th percentile of the local prevailing fees.

The bill makes several changes in the area of reimbursement for long-term-care services. Section 10 establishes a simplified cost reimbursement formula which would permit small rural hospitals to use empty beds for skilled nursing care patients without the need for separate patient placement within the facility and separate cost finding. Section 11 allows states the option of providing incentive payments to skilled nursing facilities (SNF's) or intermediate care facilities (ICF's) for efficient performance. Section 12 makes changes in the way in which SNF's and ICF's are certified under the medicaid program. Section 13 bars the Secretary of HEW from imposing numerical limits on the number of home visits which might be made by SNF or ICF patients.

The bill makes many other changes in the Social Security Act, several of which are technical in nature. Section 17 liberalizes the reimbursement criteria for ambulance service. Section 21 tightens the eligibility certification process under medicaid by prohibiting beneficiaries from transferring assets to relatives at less than market value.

Section 22 increases the rate of return on equity allowed for-profit hospitals under medicare. Section 24 provides for a 3-year trial of a competitive bidding process for laboratory services under medicaid. Section 26 removes the upper limit on home health care visits permitted medicare beneficiaries. Section 29 provides for coordinated audits by the medicare and medicaid programs. Section 31 requires SNF's to participate in both medicare and medicaid. Section 32 provides for payments to dentists for dental procedures for which reimbursement is currently made to physicians but not dentists.

5. COST ESTIMATE

[By fiscal years; in millions of dollars]

	1979	1980	1981	1982	1983
Health facilities cost commission: Estimated authorization/costs	0.2	0.2	0.2	0.2	0.3
Grants to regional pediatric pulmonary centers: Authorization level/costs	5.0	5.0	5.0	5.0	5.0
Administrative costs of coordinated audits: Estimated authorization/costs	14.5	14.5	14.5	14.5	14.5
Medicare:					
Outlays:					
Limit on routine hospital costs	−.6	−10.0	−45.0	−110.0	−225.0
Payments to States for hospital cost control programs	.3	3.9	5.8	7.2	8.8
Closure and conversion of underutilized facilities	−.3	−2.3	−5.2	−8.8	−13.2
Federal participation in capital expenditures	0	0	0	0	0
Agreement by physicians to accept assignments	5.0	85.0	85.0	90.0	95.0
Ambulatory surgery	−.5	−1.0	−1.1	−1.2	−1.3
Limit local prevailing fees	0	−10.0	−15.0	−20.0	−20.0
Increased fees for physicians in shortage areas	0	5.0	5.0	5.0	5.0
Payments for certain antigens under pt. B	(1)	(1)	(1)	(1)	(1)
Payments on behalf of deceased individuals	(1)	(1)	(1)	(1)	(1)
Hospital providers of long-term care services	0	0	0	0	0
Procedure for determining reasonable cost	(2)	(2)	(2)	(2)	(2)
Ambulance service	1.0	1.1	1.1	1.2	1.3
Increase in rate of return on equity of proprietary hospitals	0	25.0	44.8	53.7	64.5
Deductible not applicable for certain laboratory tests	0	0	0	0	0
Removal of limitations on number of home health visits	12.0	13.4	15.0	16.7	18.5
Payment for durable medical equipment	(2)	(2)	(2)	(2)	(2)
Coordinated audits	−6.0	−6.0	−6.0	−6.0	−6.0
Encouragement of philanthropic support for health care	(2)	(2)	(2)	(2)	(2)
Requirement that SNF's participate in both medicare and medicaid	(2)	(2)	(2)	(2)	(2)
Coverage of certain dentists' services	(2)	(2)	(2)	(2)	(2)
Coverage of optometrists services with respect to aphakia	1.0	1.1	1.1	1.2	1.3
Total, medicare outlays	11.9	105.2	85.5	29.0	−71.1
Medicaid:					
Required budget authority	−54.5	−85.2	−122.3	−79.9	−105.9
Outlays:					
Limit on routine hospital costs	−.5	−5.0	−30.0	−40.0	−65.0
Payments to States for hospital cost control programs	.1	1.0	1.4	1.8	2.2
Payments to promote closure and conversion of underutilized facilities	−.1	−.6	−1.3	−2.1	−3.2
Federal participation in hospital capital expenditures	(1)	(1)	(1)	(1)	(1)
Hospital providers of long-term care services	0	0	0	0	0
Reimbursement rates for SNF's and ICF's	(1)	(1)	(1)	(1)	(1)
Certification of SNF's and ICF's	0	0	0	0	0
Visits away from institution by SNF of ICF patients	0	0	0	0	0
Procedure for determining reasonable cost	(2)	(1)	(1)	(2)	(2)
Prohibition on medicaid applicant's transfer of assets to relatives at less than market value	−3.0	−4.0	−4.3	−4.6	−4.9
Competitive bidding for laboratory services	−16.0	−41.6	−53.1	0	0
Coordinated audits	−35.0	−35.0	−35.0	−35.0	−35.0
Encouragement of philanthropic support for health care	(2)	(2)	(2)	(2)	(2)
Requirement that SNF's participate in both medicare and medicaid	(1)	(1)	(1)	(1)	(1)
Total, medicaid outlays	−54.5	−85.2	−122.3	−79.9	−105.9

[1] Negligible cost or savings.
[2] Estimate not available.

Note: The costs of this bill fall within budget function 550. This bill would reduce future Federal liabilities through a change to an existing entitlement, and therefore could permit subsequent appropriation action to reduce the necessary budget authority. The figures shown as "Required budget authority" represent that amount by which budget authority could be reduced below the level needed in the absence of enactment of S. 1470.

6. Basis of estimate:

Section 2—Criteria for determining cost of routine hospital services

Savings due to the routine cost reimbursement reforms were determined by adjusting HEW simulations of individual hospital costs to reflect CBO's current policy projections for medicare and medicaid hospital expenditures for 1979–83 and to account for specific provisions of S. 1470. The HEW simulations use 1974 and 1975 data from a sample of hospitals. These sample data were adjusted to represent all hospitals.

The bill allows adjustments in routine costs to account for area wage differentials. Also, hospitals can choose to be reclassified into the next closest bed-size hospital group. The simulations take both these provisions into account.

Per diem routine hospital costs were assumed to rise at approximately 11 percent per year during the 1979–83 period. The upper limit on reimbursable costs (115 percent of each hospital group average in 1979) will increase each year by a dollar amount equal to 11 percent of each hospital group's average. This provision results in the upper limit falling to about 111 percent of the group averages by 1983.

The bill excludes from routine costs all capital costs, education and training costs, energy costs, malpractice insurance costs, and intern, resident, and nonadministrative physician costs. It is assumed that these excluded costs amount to about 25 percent of total routine costs in all hospitals.

States which have cost containment programs covering medicare and medicaid would be exempted from the provisions of section 2. Since only two States' programs now cover medicare, it was assumed that the accured savings would not be significantly affected by such exemptions.

The new reimbursement system will take the place of the present cost saving system specified under section 223 of the Social Security Amendments of 1972. The projected savings from section 223, therefore must be subtracted from the accured savings from section 2 of the Medicare-Medicaid Administration and Reimbursement Reform Act. The savings reported in the following table that would result from section 223 are based on HEW estimates.

The following table indicates the estimated accrued savings in medicare and medicaid resulting from the penalty/reward reimbursement system. Cash savings lag behind accrued savings due to billing and settlement time delays. The fiscal year 1979 savings are small because the starting date for section 2 is July 1, 1979.

[By fiscal years; in millions of dollars]

	1979	1980	1981	1982	1983
Medicare:					
Accrued savings	−14.0	−160	−250	−395	−510
Elimination of 223	+10.0	+120	+140	+165	+195
Net accrued savings	−4.0	−40	−110	−230	−320
Cash savings	−.6	−10	−45	−110	−225
Medicaid:					
Net accrued savings	−3.0	−30	−40	−65	−80
Cash savings	−.5	−5	−30	−40	−65

The HEW simulations, which form the basis of these estimates, use data for the years immediately following the removal of wage and price controls from hospitals. Hence, these data may not reflect current and future hospital behavior. Also, the simulations did not exclude capital and energy costs which could vary regionally and from hospital to hospital and thereby account for (or obscure) some of the differences in routine costs. Although the estimates excluded the average value of these costs there was no way to take account of the variation that undoubtedly exists from hospital to hospital in capital and energy costs. Such variations could affect the savings generated by S. 1470, although it is not possible with available information to determine the magnitude of the change in savings that would result if the variations were taken into account. The estimates do not assume any changes in behavior. Such changes could also alter savings.

Section 2 would also establish a Health Facilities Cost Commission. Since the bill states that HEW would provide the staff and technical support, the costs of the Commission would be those of holding the monthly Commission meetings. Salary and travel expenses of the commission members were estimated to be about $200,000 in fiscal year 1979.

In addition, section 2 provides funds for the administrative costs of State hospital cost commissions. The commissions would be reimbursed by the Federal Government for a portion of their administrative costs equal to the proportion that medicare and medicaid hospital expenditures represent of all hospital expenditures covered by the State commissions. The estimated participation and costs of this provision are:

[By fiscal years; dollar amounts in millions]

	1979	1980	1981	1982	1983
Number of States	4	13	18	21	23
Medicare	$0.3	$3.9	$5.8	$7.2	$8.8
Medicaid	$.1	$1.0	$1.4	$1.8	$2.2

Section 3—Payments to Promote Closing and Conversion of Underutilized Facilities

On the assumption that an empty bed costs half as much as an occupied bed, it was estimated from American Hospital Association data and a yearly growth rate of 12 percent, that the operating cost of an empty bed will be $40,000 in 1979. It was similarly estimated that in 1979 the value of plant assets per bed will be $51,600 and long-term debt per bed will be $22,200. For a converted bed it is estimated that the net savings after incentive payments will be $10,000 per bed in 1979. This figure was inflated by 12 percent to yield the outyear savings.

For a closed bed it is assumed that the salvage value will be one-tenth of the value of plant assets per bed. The difference between this and outstanding debt in 1980 will result in an incentive payment of $18,900 per bed. The difference between this figure and the $40,000 operating cost per bed inflated another 12 percent will yield a net savings in 1980 of $25,900 per closed bed. Similar calculations were used to derive the outyear savings.

It is assumed that 100 beds will be converted in fiscal year 1979, 250 in fiscal year 1980, 500 in fiscal year 1981, 750 in fiscal year 1982, and 1,000 in fiscal year 1983. The number of closed beds is assumed to be the same except that none will be closed in fiscal year 1979. These figures were used to derive total savings figures for all years. The medicare and Federal medicaid shares were estimated at 25 percent and 6 percent on the basis of the proportion of all hospital care financed by these programs.

Section 4—Federal participation in hospital capital expenditures

This provision strengthens the certificate-of-need process by requiring that planning agencies approve capital expenditures in excess of $150,000 as a condition of medicare and medicaid reimbursement of both capital and direct operating costs resulting from such expenditures. It is estimated that the provision will help the planning process achieve further savings, but the exact impact is difficult to separate out from the general impact of the planning program and other developments in the area of capital spending trends. Therefore the savings are estimated to be negligible.

Section 5—Agreements of physicians to accept assignment of claims

The cost estimates included here were developed by the Office of the Actuary/Medicare of HEW. They are based on estimates of the number of physicians who presently accept assignment almost exclusively and those who do so most of the time. These estimates were based on the results of a survey of physicians by the interstudy research organization. The survey results were adjusted to be consistent with the current net assignment rate of 50.5 percent. A modest increase in the number of physicians accepting assignment was assumed. The cost estimates were then derived by applying the volume of claims expected to be generated by physicians accepting assignment to the $1 administrative cost savings allowance per claim.

Section 6—Certain surgical procedures performed on an ambulatory basis

On the basis of discussions with persons knowledgeable in the issues involved in ambulatory surgery, it is estimated that modest cost savings will be generated by the provision. The estimate assumes that surgeons not now regularly accepting assignment are unlikely to perform a significantly greater number of ambulatory surgical procedures as a result of the provision. It is assumed, however, that those surgeons regularly accepting assignment, estimated at 6 percent of all surgeons, will be affected by the provision. Of these, it is assumed that one-third, or 2 percent of all surgeons, will increase significantly the number of ambulatory procedures they perform. It is assumed that these surgeons will move 10 percent of their minor operations out of hospitals as a result of the provision. From the hospital discharge survey conducted by the National Center for Health Statistics, it is estimated that approximately 10 percent of operations performed in hospitals could be performed on an ambulatory basis. From American Hospital Association data, it is estimated that 17.3 million operations will be performed in 1979. Savings per operation moved outside the hospital are estimated at $300 in 1979, equivalent to 1 day of per diem rate and some ancillary charges. The resulting savings of $1 million are assumed

to be cut in half in fiscal year 1979 by delays in implementation. Full savings are realized in fiscal year 1980 and grow thereafter at a rate consistent with CBO projections of the rate of increase in the Consumer Price Index for medical care services.

Section 7—Criteria for determining reasonable charge for physicians' services

The cost estimates included here were developed by the Office of the Actuary/Medicare of HEW. The provision affects physicians' fees in two ways. First, it limits the difference between local prevailing fees and the statewide median fee for a procedure to one-third of the latter. The savings estimate was generated by a computer simulation of the effect of the limitation using data on 1976 medicare prevailing charges for the 50 most commonly performed physician services. The second effect of the provision is to raise the allowable prevailing charge from the 50th to the 70th percentile for new and established physicians practicing in designated physician-shortage areas. The estimate is derived from data on prevailing charges and the number of physicians practicing in physician-shortage areas.

Section 8—Payment for certain antigens under part B of medicare

This provision is estimated to have a negligible cost since it affects a small number of beneficiaries.

Section 9—Payment on behalf of deceased individuals

This provision is estimated to have a zero cost since it is primarily a technical change.

Section 10—Hospital providers of long-term-care services

On the basis of discussions with the Office of the Actuary/Medicare of HEW, it is estimated that this provision will have a small, but negligible, impact on program costs. It is assumed that the cost savings generated on the inpatient side of an institution affected by the provision will be offset by the costs of the nursing care provided. This is based on the assumption that hospitals are unlikely to take advantage of the provision unless they are able to maintain their current level of revenues or increase them.

Section 11—Reimbursement rates under medicaid for skilled nursing facilities and intermediate care facilities

This provision permits states to include incentive payments for efficient performance in the determination of reasonable cost-related reimbursement for SNF's and ICF's. This could generate some additional costs and some additional savings, but the net effect is assumed to be negligible.

Section 12—Medicaid certification and approval of skilled nursing and intermediate care facilities

This provision mandates regulatory changes in the medicaid certification process for SNF's and ICF's and is not estimated to have any significant impact on program costs.

Section 13—Visits away from institution by patients of skilled nursing or intermediate care facilities

This provision makes a change in the statute that has already been implemented by the Health Care Financing Administration through

amendments to regulations. It therefore is assumed to have no incremental impact on program costs.

Section 14—Notification to State officials

This provision has no impact on program costs.

Section 15—Repeal of section 1867

This provision has no cost impact since no funding has been included in the budget for the Council.

Section 16—Procedure for determining reasonable cost or reasonable charge

An estimate of the cost impact of this provision is not available at this time. The magnitude of this cost savings would depend substantially on the regulations drafted by the Department to carry out the provision.

Section 17—Ambulance service

The estimate for fiscal year 1979 was provided by the Office of the Actuary/Medicare of HEW. It was inflated in the outyears by CBO projections of increases in the Consumer Price Index for medical care services.

Section 18—Grants to regional pediatric pulmonary centers

The $5 million authorization level is assumed to be fully appropriated in each of the next 5 fiscal years.

Section 19—Waiver for human experimentation provision for medicare and medicaid

This provision removes a legal impediment to reimbursement demonstration projects under medicare and medicaid and thus has no impact on program cost.

Section 20—Disclosure of aggregate payments to physicians

This provision prohibits the Secretary of HEW from releasing certain information and therefore has no impact on program costs.

Section 21—Resources of medicaid applicant to include certain property disposed of to applicant's relative for less than market value

The estimates shown were provided by the Medicaid Bureau of the Health Care Financing Administration. They are based on estimates of the potential number of applicants that would be affected by the provision and the average amount of assets per applicant that would be involved. The estimates of $4 million for fiscal years 1981, 1982, and 1983, were inflated by CBO projections of the rate of increase in the Consumer Price Index for medical care services.

Section 22—Rate of return on equity for for-profit hospitals

From American Hospital Association data it is estimated that the net equity per proprietary hospital in 1976 was $2.4 million. The historical annual growth rate of total assets per proprietary hospital is approximately 20 percent. This rate was used to update the equity figure to fiscal year 1979 and also to project it in the outyears. The simulation of the routine cost limits described in the explanation of the estimates for section 2 provided the percentage of proprietary hospitals that would be entitled to a higher rate of return than currently allowed. These percentages were applied to the number of proprietary hospitals

listed by the AHA in 1976 to yield 349 hospitals that would receive an additional 7 percent rate of return and 188 hospitals that would receive an additional 3.5 percent rate of return. The growth rate of 20 percent, the number of hospitals, the equity figure, and the incremental rate of return were multiplied to yield a total cost figure. Medicare and federal medicaid shares were estimated at 25 percent and 6 percent on the basis of the proportion of all hospital care financed by these programs. Delays in implementation and lags due to the phasing of hospital accounting years were assumed to eliminate any savings in fiscal year 1979 and to reduce them by one-third in fiscal year 1980.

Section 23—Deductible not applicable to expenses for certain independent laboratory tests

On the basis of discussions with the Office of the Actuary/Medicare of HEW, it is assumed that this provision will have a negligible cost impact. The provision corrects a drafting error made in the 1972 amendments and waives the deductible requirement for certain laboratory services. It is likely, however, that most beneficiaries would have met the deductible already. Laboratories now probably forgo collecting the copayment because of the administrative cost involved. If the copayment is waived, however, laboratories would have to accept assigned billing. The resulting change in financial incentives to laboratories therefore would be small.

Section 24—Payment for laboratory services under medicaid

This provision was assumed to be identical to section 4(b) of S. 705, for which an earlier cost estimate is available. It was estimated as follows:

A Federal medicaid laboratory fee base of $128 million was assumed for 1979 (based on data from the Senate Special Committee on Aging). A savings rate was derived from studies conducted in New York, New Jersey, and California on the effects of a competitive bidding process. Their reported savings ranged from 20 to 50 percent. A 25-percent savings rate was assumed for the first year during which competitive bidding would be in effect. Thereafter, it was assumed that as experience was gained with the competitive bidding process, the rate of growth in the laboratory fee base would decline from 15 percent a year to 10 percent. The result is that the net savings rate would grow to 30 percent by 1981. Time delays for implementing the bidding process were assumed to reduce the savings in 1979 by 50 percent. Full savings were assumed in outyears. It should also be noted that the program is only authorized through 1981.

Section 25—Status of professional standards review organizations

The provision clarifies the status of PSRO's with respect to disclosure of confidential information. It has no impact on program costs.

Section 26—Removal of 3-day requirement and 100-visit limitation for home health services

A cost estimate for this provision of $12 million for fiscal year 1979 was provided by the Office of the Actuary/Medicare of HEW. It was based on estimates of the increased utilization likely to occur as a result of a nearly total absence of a limitation on home health

services created by the provision. The estimate was inflated in the outyears by CBO projections of the rate of increase in the Consumer Price Index for medical care services and by an assumed 3-percent annual increase in utilization.

Section 27—Payment for durable medical equipment

An estimate of the cost impact of this provision is not available at this time.

Section 28—Development of uniform claims forms for use under health care programs

This provision requires HEW to develop standardized claims forms for medicare and medicaid. It is estimate to have no impact on program costs over the next 5 fiscal years.

Section 29—Coordinated audits under the Social Security Act

Sixteen States presently do not have coordinated audit programs. HEW estimates that it would cost $14.5 million to conduct coordinated audits in those States. The audits are expected to result in $58 million in reclaimed medicaid benefits in each of the next 5 years, the Federal share of which would be $35 million per year. HEW further estimates that $6 million would be saved in medicare funds each year.

Section 30—Encouragement of philanthropic support for health care

An estimate of the cost impact of this provision is not possible at this time.

Section 31—Participation under medicaid by skilled nursing facilities participating under medicare

It is estimated that this provision will have a negligible impact on program costs. Some facilities may cease their program participation rather than comply, but the number of such cases is likely to be small.

Section 32—Coverage under medicare of certain dentists' services

This provision is likely to result in some additional program costs. A specific cost estimate, however is not possible at this time because specific draft language was not made available.

Section 33—Coverage under medicare of optometrists' services with with respect to aphakia

A cost estimate for this provision of $1 million was provided by the Office of the Actuary/Medicare of HEW. It was inflated in the outyears by CBO projections of the rate of increase in the Consumer Price Index for medical care services.

7. Estimate comparison: HEW has estimated the savings resulting from the change in the reimbursement system provided in section 2. For the first 3 years the HEW and CBO estimates do not differ significantly. The CBO estimates of savings for 1982 and 1983 are higher due to different estimated impacts of the provision which excludes one-half of costs in excess of the upper limit in the calculation of the group averages. CBO's and HEW's estimates of the savings from the reimbursement reform are as follows:

[By fiscal years; in millions of dollars]

	1979	1980	1981	1982	1983
CBO	−1.1	−15	−75	−150	−290
HEW	(1)	−10	−70	−120	−175

[1] Less than $5,000,000.

HEW's and CBO's estimates also differ significantly on three other sections. The table below compares the combined costs/savings for medicare and medicaid for both estimates.

[By fiscal years; in millions of dollars]

	1979	1980	1981	1982	1983
Sec. 3—Closing and conversion of underutilized facilities:					
CBO	−0.4	−2.9	−6.5	−10.9	−16.4
HEW	0	−6.0	−41.0	−76.0	−93.0
Sec. 6—Ambulatory surgery:					
CBO	−.5	−1.0	−1.1	−1.2	−1.3
HEW	0	(1)	(1)	(1)	(1)
Sec. 7—Rate of return on equity for proprietary hospitals:					
CBO	0	25.0	44.8	53.7	64.5
HEW	0	33.0	67.0	76.0	85.0

[1] Estimate not available.

8. Previous CBO estimate: None.

9. Estimate prepared by Eric Weadum and Lawrence Wilson.

10. Estimate approved by James L. Blum, Assistant Director for Budget Analysis.

IV. Vote of the Committee in Reporting the Bill

In compliance with section 133 of the Legislative Reorganization Act of 1946, the following statement is made relative to the vote by the committee to report the bill. The bill was ordered favorably reported by voice vote.

V. Regulatory Impact

In accordance with paragraph 5 of rule XXIX of the Standing Rules of the Senate, the following statement of the regulatory impact of the bill is made.

In implementing the various provisions of the bill there will be some increase in Federal regulatory activity. It is not anticipated, however, that the legislation would impose an unusual or burdensome regulatory effect. Several provisions will, in fact, decrease regulatory activity and associated paperwork.

Section 2 of the bill would generate the most significant new regulatory activity since a new method of reimbursement under medicare and medicaid is required. Revised regulations will be necessary to implement a procedure for determining hospital "target" rates, as well as implement a procedure for determining exceptions to those rates. In addition, the Secretary would be required to implement procedures to evaluate State ratemaking programs for the purpose of determining exemptions from the Federal program.

The authorization for payments under the legislation to promote closing and conversion of underutilized facilities establishes a new procedure that would also require implementing regulations.

A provision modifying the medicaid eligibility test would require additional paperwork for the program on individuals (in those States not currently applying such a test) through imposing a transfer of assets test on potential medicaid eligibles.

Provisions that will decrease regulations and paperwork include the simplified reimbursement procedure for long-term-care services provided by small rural hospitals; simplified claims procedure for "participating" physicians; coordinated audits under titles V, XVIII, and XIX; uniform claims forms under titles XVIII and XIX; prohibition against routine disclosure of aggregate payments to physicians; waiver of laboratory deductible under medicare; authority for States to contract for clinical laboratory services under medicaid, and clarification of present law regarding approval requirements for the changes of ownership of existing facilities which create no new beds or services.

Other provisions in the bill would have regulatory implications primarily for the agency administering the program and would have minimal regulatory effect on individuals or providers of services.

Since several of the new reimbursement procedures established by the bill are designed to moderate the rate of increase in the cost of health care services provided under titles V, XVIII, and XIX, the bill will have an economic effect on the entities providing services under these programs.

VI. Changes in Existing Law

In compliance with paragraph 4 of rule XXIX of the Standing Rules of the Senate, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

RAILROAD RETIREMENT ACT

* * * * * * *

"POWERS AND DUTIES OF THE BOARD

SEC. 7.

* * * * * * *

(d)(1) The Board shall, for purposes of this subsection, have the same authority to determine the rights of individuals described in subdivision (2) to have payments made on their behalf for hospital insurance benefits consisting of inpatient hospital services, posthosptal extended care services, [posthospital] home health services, and outpatient hospital diagnostic services (all hereinafter referred to as "services") under section 226, and parts A and C of title XVIII, of the Social Security Act as the Secretary of Health, Education, and Welfare has under such section and such parts with respect to individuals to whom such sections and such parts apply. For purposes of section 8, a determination with respect to the rights of an individual

under this subsection shall, except in the case of a provider of services, be considered to be a decision with respect to an annuity.

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SOCIAL SECURITY ACT, AS AMENDED

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TITLE II—FEDERAL OLD-AGE, SURVIVORS, AND DISABILITY INSURANCE BENEFITS

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Entitlement to Hospital Insurance Benefits

Sec. 226.

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(c) For purposes of subsection (a)—

(1) entitlement of an individual to hospital insurance benefits for a month shall consist of entitlement to have payment made under, and subject to the limitations in, part A of title XVIII on his behalf for inpatient hospital services, post-hospital extended care services, and [post-hospital] home health services (as such terms are defined in part C of title XVIII) furnished him in the United States (or outside the United States in the case of inpatient hospital services furnished under the conditions described in section 1814(f)) during such month; except that (A) no such payment may be made for post-hospital extended care services furnished before January 1967, and (B) no such payment may be made for post-hospital extended care services or [post-hospital] home health services unless the discharge from the hospital required to qualify such services for payment under part A of title XVIII occurred (i) after June 30, 1966, or on or after the first day of the month in which he attains age 65, whichever is later, or (ii) if he was entitled to hospital insurance benefits pursuant to subsection (b), at a time when he was so entitled; and

(2) an individual shall be deemed entitled to monthly insurance benefits under section 202 or section 223, or to be a qualified railroad retirement beneficiary, for the month in which he died if he would have been entitled to such benefits, or would have been a qualified railroad retirement beneficiary, for such month had he died in the next month.

* * * * * * *

TITLE V—MATERNAL AND CHILD HEALTH AND CRIPPLED CHILDREN'S SERVICES

* * * * * * *

Purposes for Which Funds Are Available

Sec. 502. Appropriations pursuant to section 501 shall be available for the following purposes in the following proportions:

(1) In the case of the fiscal year ending June 30, 1969, and each of the next 5 fiscal years, (A) 50 percent of the appropriation

for such year shall be for allotments pursuant to sections 503 and 504; (B) 40 percent thereof shall be for grants pursuant to sections 508, 509, and 510; and (C) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511 and 512.

(2) In the case of the fiscal year ending June 30, 1975, and each fiscal year thereafter, (A) 90 percent of the appropriation for such years shall be for allotments pursuant to sections 503 and 504; and (B) 10 percent thereof shall be for grants, contracts, or other arrangements pursuant to sections 511(*a*) and 512.

Not to exceed 5 percent of the appropriation for any fiscal year under this section shall be transferred, at the request of the Secretary, from one of the purposes specified in paragraph (1) or (2) to another purpose or purposes so specified. For each fiscal year, the Secretary shall determine the portion of the appropriation, within the percentage determined above to be available for sections 503 and 504, which shall be available for allotment pursuant to section 503 and the portion thereof which shall be available for allotment pursuant to section 504. Notwithstanding the preceding provisions of this section, of the amount appropriated for any fiscal year pursuant to section 501, not less than 6 percent of the amount appropriated shall be available for family planning services from allotments under section 503 and for family planning services under projects under sections 508 and 512.

* * * * * * *

Approval of State Plans

Sec. 505. (a) In order to be entitled to payments from allotments under section 592, a State must have a State plan for maternal and child health services and services for crippled children which—

* * * * * * *

(14) provides that acceptance of family planning services provided under the plan shall be voluntary on the part of the individual to whom such services are offered and shall be a prerequisite to eligiblity for or the receipt of any service under the plan; [and]

(15) provides—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of services under the plan and, where applicable, for providing guidance with respect thereto to the other State agency referred to in paragraph (2); and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1864(a), or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform the function of determining whether institutions and agencies meet the requirements for participation in the program under the plan under this title [o]; *and*

(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of the portion of costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.

Payments

SEC. 506. (a) * * *

(f) Notwithstanding the preceding provisions of this section, no payment shall be made to any State thereunder—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)] *subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)* ; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2) ; or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for services furnished under the plan by a hospital unless such hospital has in effect a utilization review plan which meets the requirement imposed by section 1861(k) for purposes of title XVIII; and if such hospital has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph in any State if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures

which are superior in their effectiveness to the procedures required under section 1861(k).

* * * * * * *

(h) For additional exclusions from reasonable cost and reasonable charge see section 1130.

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Training of Personnel

Sec. 511. *(a)* From the sums available under clause (C) of paragraph (1) or clause (B) of paragraph (2) of section 502, the Secretary is authorized to make grants to public or nonprofit private institutions of higher learning for training personnel for health care and related services for mothers and children, particularly mentally retarded children and children with multiple handicaps. In making such grants the Secretary shall give special attention to programs providing training at the undergraduate level.

(b)(1) From the sums availble under paragraph (2) the Secretary is authorized to make grants to public or nonprofit private regional pediatric pulmonary centers, which are a part of (or are affiliated with) an institution of higher learning, to assist them in carrying out a program for the training and instruction (through demonstrations and otherwise) of health care personnel in the prevention, diagnosis, and treatment of respiratory diseases in children and young adults, and in providing (through such program) needed health care services to children and young adults suffering from such diseases.

(2) For the purpose of making grants under this subsection, there are authorized to be appropriated, for the fiscal year ending September 30, 1979, and each of the next four succeeding fiscal years, such sums (not in excess of $5,000,000 for any fiscal year) as may be necessary. Sums authorized to be appropriated for any fiscal year under this subsection for making grants for the purposes referred to in paragraph (1) shall be in addition to any sums authorized to be appropriated for such fiscal year for similar purposes under other provisions of this title.

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

Part A—General Provisions

* * * * * * *

Disclosure of Information in Possession of Department

Sec. 1106. (a) * * *

(f) The Secretary shall not make available, nor shall the State title XIX agency be required to make available to the public, information relating to the amounts that have been paid to individual doctors of

medicine or osteopathy by or on behalf of beneficiaries of the health programs established by title XVIII or XIX, as the case may be, except as may be necessary to carry out the purposes of those titles or as may be specifically required by the provisions of other Federal law.

* * * * * * *

Limitation on Federal Participation for Capital Expenditures

Sec. 1122. (a) * * *

[(b) The Secretary, after consultation with the Governor (or other chief executive officer) and with appropriate local public officials, shall make an agreement with any State which is able and willing to do so under which a designated planning agency (which shall be an agency described in clause (ii) of subsection (d)(1)(B) that has a governing body or advisory board at least half of whose members represent consumer interests) will—

[(1) make, and submit to the Secretary together with such supporting materials as he may find necessary, findings and recommendations with respect to capital expenditures proposed by or on behalf of any health care facility or health maintenance organization in such State within the field of its responsibilities.

[(2) receive from other agencies described in clause (ii) of subsection (d)(1)(B), and submit to the Secretary together with such supporting material as he may find necessary, the findings and recommendations of such other agencies with respect to capital expenditures proposed by or on behalf of health care facilities or health maintenance organizations in such State within the fields of their respective responsibilities, and

[(3) establish and maintain procedures pursuant to which a person proposing any such capital expenditure may appeal a recommendation by the designated agency and will be granted an opportunity for a fair hearing by such agency or person other than the designated agency as the Governor (or other chief executive officer) may designate to hold such hearings,

[whenever and to the extent that the findings of such designated agency or any such other agency indicate that any such expenditure is not consistent with the standards, criteria, or plans developed pursuant to the Public Health Service Act (or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963) to meet the need for adequate health care facilities in the area covered by the plan or plans so developed.

[(c) The Secretary shall pay any such State from the Federal Hospital Insurance Trust Fund, in advance or by way of reimbursement as may be provided in the agreement with it (and may make adjustments in such payments on account of overpayments or underpayments previously made), for the reasonable cost of performing the functions specified in subsection (b).

[(d)(1) Except as provided in paragraph (2), if the Secretary determines that—

[(A) neither the planning agency designated in the agreement described in subsection (b) nor an agency described in clause (ii) of subparagraph (B) of this paragraph had been given notice

of any proposed capital expenditure (in accordance with such procedure or in such detail as may be required by such agency) at least 60 days prior to obligation for such expenditure; or

[(B) (i) the planning agency so designated or an agency so described had received such timely notice of the intention to make such capital expenditure and had, within a reasonable period after receiving such notice and prior to obligations for such expenditure, notified the person proposing such expenditure that the expenditure would not be in conformity with the standards, criteria, or plans developed by such agency or any other agency described in clause (ii) for adequate health care facilities in such State or in the area for which such other agency has responsibility, and

[(ii) the planning agency so designated had, prior to submitting to the Secretary the findings referred to in subsection (b)—

[(I) consulted with, and taken into consideration the findings and recommendations of, the State planning agencies established pursuant to sections 314(a) and 604(a) of the Public Health Service Act (to the extent that either such agency is not the agency so designated) as well as the public or nonprofit private agency or organization responsible for the comprehensive regional, metropolitan area, or other local area plan or plans referred to in section 314(b) of the Public Health Service Act and covering the area in which the health care facility or health maintenance organization proposing such capital expenditure is located (where such agency is not the agency designated in the agreement), or, if there is no such agency, such other public or nonprofit private agency or organization (if any) as performs, as determined in accordance with criteria included in regulations, similar functions, and

[(II) granted to the person proposing such capital expenditure an opportunity for a fair hearing with respect to such findings;

[then, for such period as he finds necessary in any case to effectuate the purpose of this section, he shall, in determining the Federal payments to be made under titles, V, XVIII, and XIX with respect to services furnished in the health care facility for which such capital expenditure is made, not include any amount which is attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), or other expenses related to such capital expenditure. With respect to any organization which is reimbursed on a per capita or a fixed fee or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII, and XIX, the Secretary shall exclude an amount which in his judgment is a reasonable equivalent to the amount which would otherwise be excluded under this subsection if payment were to be made on other than a per capita or a fixed fee or negotiated rate basis.

[(2) If the Secretary, after submitting the matters involved to the advisory council established or designated under subsection (i), determines that an exclusion of expenses related to any capital expenditure of any health care facility or health maintenance organization

would discourage the operation or expansion of such facility or organization, or of any facility of such organization, which has demonstrated to his satisfaction proof of capability to provide comprehensive health care services (including institutional services) efficiently, effectively, and economically, or would otherwise be inconsistent with the effective organization and delivery of health services or the effective administration of title V, XVIII, or XIX, he shall not exclude such expenses pursuant to paragraph (1).]

(c) Expenses incurred by designated planning agencies shall be payable from—

(1) funds in the Federal Hospital Insurance Trust Fund,

(2) funds in the Federal Supplementary Medical Insurance Trust Fund, and

(3) funds appropriated to carry out the health care provisions of the several titles of this Act,

in such amounts as the Secretary finds result in a proper allocation. The Secretary shall transfer money between the funds as may be appropriate to settle accounts between them. The Secretary shall pay the designated planning agencies without requiring contribution of funds by any State or political subdivision thereof.

(d) (1) Except as provided in paragraph (2), if the Secretary determines that—

(A) the designated planning agency had not approved the proposed expenditure; and

(B) the designated planning agency had granted to the person proposing the capital expenditure an opportunity for a fair hearing with respect to the findings;

then, in determining Federal payments under titles V, XVIII, and XIX for services furnished in the health care facility for which the capital expenditure is made, the Secretary shall not include any amount attributable to depreciation, interest on borrowed funds, a return on equity capital (in the case of proprietary facilities), other expenses related to the capital expenditure, or for direct operating costs, to the extent that they can be directly associated with the capital expenditure, unless the designated planing agency for the State determines, in accordance with an agreement entered into under subsection (b) or under a certificate of need program which is applicable to such expenditure and which meets the requirements of Title XV of the Public Health Service Act, that such capital expenditures are needed and criteria adopted by such agency. In the case of a proposed capital expenditure in a standard metropolitan statistical area which encompasses more than one jurisdiction, that expenditure shall require approval of the designated planning agency of each jurisdiction, which shall jointly review the proposal. Where the designated planning agencies to do unanimously agree, the proposed expenditure shall be deemed disapproved. Where the designated planning agencies do not act to approve or disapprove the proposed expenditure within one hundred and eighty days after the submission of the request for approval, the proposed expenditure shall be deemed approved. Any deemed approval or disapproval shall be subject to review and reversal by the Secretary following a request, submitted to him within sixty days of the deemed approval or disapproval, for a review and reconsideration based upon

the record. With respect to any organization which is reimbursed on a per capita, fixed fee, or negotiated rate basis, in determining the Federal payments to be made under titles V, XVIII and XIX, the Secretary shall exclude an amount reasonably equivalent to the amount which would otherwise be excluded under this subsection if payment were made on other than a per capita, fixed fee, or negotiated rate basis.

(2) If the Secretary, after submitting the matters involved to the advisory council established under subsection (i), determines that an exclusion of expenses related to any capital expenditure would discourage the operation or expansion of any health care facility or health maintenance organization which has demonstrated to his satisfaction proof of its capability to provide comprehensive health care services (including institutional services) effectively and economically, or would be inconsistent with effective organization and delivery of health services, or the effective administration of title V, XVIII, or XIX), he shall not exclude the expenses pursuant to paragraph (1).

* * * * * * *

[(g) For the purposes of this section, a "capital expenditure" is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $100,000, (2) changes the bed capacity of the facility with respect to which such expenditure is made, or (3) substantially changes the services of the facility with respect to which such expenditure is made. For purposes of clause (1) of the preceding sentence, the cost of the studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment with respect to which such expenditure is made shall be included in determining whether such expenditure exceeds $100,000.]

(g) For purposes of this section, a 'capital expenditure' is an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance and which (1) exceeds $150,000, (2) changes the bed capacity of the facility, or (3) substantially changes the services of the facility, including conversion of existing beds to higher cost usage. The cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the plant and equipment shall be included in determining whether the expenditure exceeds $150,000. For purposes of this section, 'capital expenditure' does not include an expenditure for the purpose of acquiring (either by purchase or under lease or comparable arrangement) an existing health care facility, the utilized services and bed capacity of which are not increased as a result of the acquisition.

* * * * * * *

HEALTH FACILITIES COSTS COMMISSION

SEC. 1127. (a) There is established a commission to be known as the Health Facilities Costs Commission (hereinafter in this section referred to as the 'Commission').

(b)(1) The Commission shall be composed of eleven members appointed by the Secretary—

(A) three of whom are individuals who are representatives of hospital administrators,

(B) two of whom are practicing physicians in hospitals, and

(C) six of whom are consumers of health care, and each of whom, as a result of training, experience, or attainments, is exceptionally well qualified to assist in serving and carrying out the functions of the Commission. One of the members of the Commission shall, at the time of appointment, be designated as Chairman of the Commission. The Secretary shall first appoint members to the Commission not later than January 1, 1979.

(2) No individual who is a full-time employee or officer of the United States may be appointed as a member of the Commission.

(3) The Chairman of the Commission shall designate a member of the Commission to act as Vice Chairman of the Commission.

(4) A majority of the members of the Commission shall constitute a quorum, but a lesser number may conduct hearings.

(5) A vacancy in the Commission shall not affect its powers, but shall be filled in the same manner as that herein provided for the appointment of the member first appointed to the vacant position.

(6) Members of the Commission shall be appointed for a term of four years, except that the Secretary shall provide for such shorter terms for some of the members first appointed so as to stagger the date of expiration of members' terms of office.

(7) No individual may be appointed to serve more than two terms as a member of the Commission.

(8) Each member of the Commission shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent of the annual rate of basic pay in effect for grade GS–18 of the General Schedule for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission, and all members of the Commission shall be allowed, while away from their homes or regular places of business in the performance of service for the Commission, travel expenses (including per diem in lieu of subsistence) in the same manner as persons employed intermittently in the Government service are allowed expenses under section 5703 of title 5, United States Code.

(9) The Commission shall meet at the call of the Chairman, or at the call of a majority of the members of the Commission; but meetings of the Commission shall be held not less frequently than once in each calendar month which begins after a majority of the authorized membership of the Commission has first been appointed.

(c) It shall be the duty and function of the Commission to conduct a continuing study, investigation, and review of the reimbursement of hospitals for care provided by them to individuals covered under title XVIII or under State plans approved under title XIX, with particular attention to the criteria established by section 1861(bb) (hereinafter in this section referred to as the 'reimbursement reform program') with a view to devising and recommending, from time to time but not less frequently than once each calendar year (beginning with the calendar year 1979), to the Secretary and the Congress measures—

(A) for the improvement of the reimbursement reform program, and

(B) for the possible application (i) of the reimbursement reform program to providers of service other than hospitals, and (ii) of classification and comparison techniques similar to those applied to adjusted routine costs of hospitals under section 1861 (bb) to other costs of hospitals and other providers of services.

(d) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Commission may need.

(e) The Commission may secure directly from any department or agency of the United States such data and information as may be necessary to enable it to carry out its duties under this section. Upon request of the Chairman of the Commission, any such department or agency shall furnish any such data or information to the Commission.

(f) There are hereby authorized to be appropriated such sums as may be necessary to carry out this section.

(g) Section 14 of the Federal Advisory Committee Act shall not apply to the Commission.

PAYMENTS TO PROMOTE CLOSING AND CONVERSION OF UNDERUTILIZED FACILITIES

SEC. 1128. (a)(1)(A) Before the end of the third full month following the month in which this section is enacted, the Secretary shall establish a Hospital Transitional Allowance Board (hereinafter in this section referred to as the 'Board'). The Board shall have five members, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, who are knowledgeable about hospital planning and hospital operations.

(B) Members of the Board shall be appointed for three-year terms, except some initial members shall be appointed for shorter terms to permit staggered terms of office.

(C) Members of the Board shall be entitled to per diem compensation at rates fixed by the Secretary, but not more than the current per diem equivalent at the time the service involved is rendered for grade GS–18 under section 5332 of title 5, United States Code.

(D) The Secretary shall provide such technical, secretarial, clerical, and other assistance as the Board may need.

(2) The Board shall receive and act upon applications by hospitals, certified for participation (other than as 'emergency hospitals') under titles XVIII and XIX, for transitional allowances.

(b) For purposes of this section—

(1) The term "transitional allowance" means an amount which—

(A) shall, solely by reason of this section, be included in a hospital's reasonable cost for purposes of calculating payments under the programs authorized by title V, XVIII, and XIX of this Act; and

(B) in accordance with this section, is established by the Secretary for a hospital in recognition of a reimbursement detriment (as defined in paragraph (3)) experienced because of a qualified facility conversion (as defined in paragraph (2)).

(2) *The term "qualified facility conversion" means closing, modifying, or changing the usage of an underutilized hospital facility which is expected to benefit the programs authorized under title V, title XVIII and title XIX by (A) eliminating excess bed capacity, (B) discontinuing an underutilized service for which there are adequate alternative sources, or (C) substituting for the underutilized service some other service which is needed in the area and which is consistent with the findings of an appropriate health planning agency.*

(3) *A hospital which has carried out a qualified facility conversion and which continues in operation will be regarded as having experienced a "reimbursement detriment"—*

(A) to the extent that, solely because of the conversion, there is a reduction in that portion of the hospital's costs attributable to capital assets which are taken into account in determining reasonable cost for purposes of determining amount of payment to the hospital under title V, title VXIII, or a State plan approved under title XIX;

(B) if the conversion results, an an interim basis, in increased operating costs, to the extent that operating costs exceed amounts ordinarily reimbursable under title V, title XVIII and the State plan approved under title XIX; or

(C) in the case of complete closure of a private nonprofit hospital, or local governmental hospital, other than for replacement of the hospital, to the extent of actual debt obligations previously recognized as reasonable for reimbursement, where the debt remains outstanding, less any salvage value.

(c) (1) *Any hospital may file an application with the Board (in a form and including data and information as the Board, with the approval of the Secretary, may require) for a transitional allowance with respect to any qualified conversion which was formerly initiated after December 31, 1978. The Board, with the approval of the Secretary, may also establish procedures, consistent with this section, by means of which a finding of a reimbursement detriment may be made prior to the actual conversion.*

(2) *The Board shall consider any application filed by a hospital and if the Board finds that—*

(A) the facility conversion is a qualified facility conversion, and

(B) the hospital is experiencing or will experience a reimbursement detriment because it carried out the qualified facility conversion,

the Board shall transmit to the Secretary its recommendation that the Secretary establish a transitional allowance for the hospital in amounts reasonably related to prior or prospective use of the facility under title V, title XVIII and the State plan approved under title XIX, for a period, not to exceed twenty years as specified by the Board, and, if the Board finds that the criteria in subparagraphs (A) and (B) are not met, it shall advise the Secretary not to establish a transitional allowance for that hospital. For an approved closure under subsection (b) (3) (C) the Board may recommend or the Sec-

retary may approve, a lump-sum payment in lieu of periodic allowances, where such payment would constitute a more efficient and economic alternative.

(3)(A) The Board shall notify a hospital of its findings and recommendations.

(B) A hospital dissatisfied with a recommendation may obtain an informal or formal hearing, at the discretion of the Secretary by filing (in the form and within a time period established by the Secretary) a request for a hearing.

(4)(A) Within thirty days after receiving a recommendation from the Board respecting a transitional allowance or, if later, within thirty days after a hearing, the Secretary shall make a final determination whether, and if so in what amount and for what period of time, a transitional allowance will be granted to a hospital. A final determination of the Secretary shall not be subject to judicial review.

(B) The Secretary shall notify a hospital and any other appropriate parties of the determination.

(C) Any transitional allowance shall take effect on a date prescribed by the Secretary, but not earlier than the date of completion of the qualified facility conversion. A transitional allowance shall be included as an allowable cost item in determining the reasonable cost incurred by the hospital in providing services for which payment is authorized under this Act, except that the transitional allowance shall not be considered in applying limits to costs recognized as reasonable pursuant to the third sentence of section 1861(v)(1) and section 1861(bb) of this Act, or in determining the amount to be paid to a provider pursuant to section 1814(b), section 1933(a)(2), section 1910(i)(3), and section 506(f)(3) of this Act.

(d) In determining the reasonable cost incurred by a hospital with respect to which payment is authorized under a State plan approved under title V or title XIX, any transitional allowance shall be included as an allowable cost item.

(e)(1) The Secretary is authorized to establish transitional allowances only as provided in paragraphs (2) and (3).

(2) Prior to January 1, 1982, the Secretary is authorized to establish a transitional allowance for not more than fifty hospitals.

(3) On and after January 1, 1982, the Secretary is authorized to establish a transitional allowance for any hospital which qualifies for such an allowance under the provisions of this section.

(4) On or before January 1, 1981, the Secretary shall report to the Congress evaluating the effectiveness of the program established under this section including appropriate recommendations.

NOTIFICATION TO STATE OFFICIALS

SEC. 1129. If the Secretary notifies a State of any audit, quality control performance report, deficiency, or any reduction, termination, or increase in Federal matching, under the State plan for any program for which Federal payments are made under this Act, simultaneous notification shall also be made to the Governor of the State and the respective chairmen of the legislative and appropriation committees of that State's legislature having jurisdiction over the program affected.

EXCLUSION OF CERTAIN ITEMS IN DETERMINING REASONABLE COST AND REASONABLE CHARGE

SEC. 1130. (a) Except as otherwise provided in subsection (b), in determining the amount of any payment under title XVIII, under a program established under title V, or under a State plan approved under title XIX of this Act, when the payment is based upon the reasonable cost or reasonable charge, no element comprising any part of the cost or charge shall be considered to be reasonable if, and to the extent that, such element is—

(1) a commission, finder's fee, or for a similar arrangement, or

(2) an amount payable for any facility (or part or activity thereof) under any rental or lease arrangement which is, directly or indirectly, determined, wholly or in part as a percentage, fraction, or portion of the charge or cost attributed to any health service (other than the element) or any health service including, but not limited to, the element.

(b) The Secretary shall by regulations establish exceptions to the provisions of subsection (a) with respect to any element of cost or charge which consists of payments based on a percentage arrangement, if such element is otherwise reasonable and the percentage arrangement—

(1) is a customary commercial business practice, or

(2) provides incentives for the efficient and economical operation of the health service.

* * * * * * *

DEVELOPMENT OF UNIFORM CLAIMS FORMS FOR USE UNDER HEALTH CARE PROGRAMS

SEC. 1132. (a) Within the 2-year period commencing on the date of enactment of this section, the Secretary shall to the maximum extent possible develop and require to be employed, in the administration of the health insurance for the aged and disabled program established by title XVIII and the medical assistance programs approved under title XIX, uniform claims forms which shall be utilized in making payment for health services under such programs. Such claims forms may vary in form and content, but only to the extent clearly required.

(b) The Secretary shall require forms developed pursuant to subsection (a) to be utilized in the administration of health care programs (other than those referred to in subsection (a)) but over which he has administrative responsibility, if he determines that such use is in the interest of effective administration of such programs.

(c) The Secretary, in carrying out the provisions of subsection (a) shall consult with those charged with the administration of Federal programs (other than those referred to in subsections (a) and (b)) and with other organizations and persons that pay for health care, and with the concerned providers of health care services, with the objective of having a broad representation of such programs and plans to facilitate and encourage maximum use by other programs of such uniform claims forms.

COORDINATED AUDITS

SEC. 1133. If an entity provides services reimbursable on a cost-related basis under title V or XIX, as well as services reimbursable on such a basis under title XVIII, the Secretary shall require, as a condition for payment to any State under title V or XIX with respect to administrative costs incurred in the performance of audits of the books, accounts, and records of that entity, that these audits be coordinated through common audit procedures with audits performed with respect to the entity for purposes of title XVIII. The Secretary shall apportion to the program established under title V or XIX that part of the cost of coordinated audits which is attributable to each such program and which would not have otherwise been incurred in an audit of the program established under title XVIII. Where the Secretary finds that a State has declined to participate in such a common audit with respect to title V or XIX, he shall reduce the payments otherwise due such State under such title by an amount which he estimates to be the amount that represents the duplication of costs resulting from such State's failure to participate in the common audit.

ENCOURAGEMENT OF PHILANTHROPIC SUPPORT FOR HEALTH CARE

SEC. 1134. (a) It is the policy of the Congress that philanthropic support for health care be encouraged and expanded, especially in support of experimental and inovative efforts to improve the health care delivery system and access to health care services.

(b) (1) For purposes of determining, under title XVIII or XIX, the reasonable costs of any service furnished by a provider of health services—

(A) except as provided in paragraph (2), unrestricted grants, gifts, and endowments, and income therefrom, shall not be deducted from the operating costs of such provider, and

(B) grants, gifts, and endowment income designated by a donor for paying specific operating costs of such provider shall be deducted from the particular operating costs or group of costs involved.

(2) Income from endowments and investments may be used to reduce interest expense, if such income is from an unrestricted gift or grant and is commingled with other funds, except that in no event shall any such interest expense be reduced below zero by any such income.".

Part B—Professional Standards Review

* * * * * * *

Prohibition Against Disclosure of Information

Sec. 1166. (a) Any data or information acquired by any Professional Standards Review Organization, in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part, (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure

adequate protection of the rights and interests of patients, health care practitioners, or providers of health care, or (3) in accordance with subsection (b).

(b) A Professional Standards Review Organization shall provide, in accordance with procedures established by the Secretary, data and information—

(1) to assist Federal and State agencies recognized by the Secretary as having responsibility for identifying and investigating cases or patterns of fraud or abuse, which data and information shall be provided by such organization to such agencies at the request of such agencies at the discretion of such Organization on the basis of its findings with respect to evidence of fraud or abuse; and

(2) to assist the Secretary, and such Federal and State agencies recognized by the Secretary as having health planning or related responsibilities under Federal or State law (including health systems agencies and State health planning and development agencies), in carrying out appropriate health care planning and related activities, which data and information shall be provided in such format and manner as my be prescribed by the Secretary or agreed upon by the responsible Federal and State agencies and such Organization, and shall be in the form of aggregate statistical data (without identifying any individual) on a geographic, institutional, or other basis reflecting the volume and frequency of services furnished, as well as the demographic characteristics of the population subject to review by such Organization.

The penalty provided in subsection (c) shall not apply to the disclosure of any data and information received under this subsection, except that such penalty shall apply to the disclosure (by the agency receiving such data and information) of any such data and information described in paragraph (1) unless such disclosure is made in a judicial, administrative, or other formal legal proceeding resulting from an investigation conducted by the agency receiving the data and information.

(c) It shall be unlawful for any person to disclose any such information other than for such purposes, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1,000, and imprisoned for not more than six months, or both, together with the costs of prosecution.

(d) No patient record in the possession of a Professional Standards Review Organization, a Statewide Professional Standards Review Council, or the National Professional Standards Review Council shall be subject to subpena or discovery proceedings in a civil action.

(e) *No Professional Standards Review Organization and no Statewide Professional Standards Review Council shall be considered to be or have been an 'agency' or authority of the Government of the United States' for the purpose of disclosure of information developed or collected, at any time, in carrying out functions under this Act.*

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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Part A—Hospital Insurance Benefits for the Aged and Disabled

Description of Program

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Scope of Benefits

Sec. 1812. (a) The benefits provided to an individual by the insurance program under this part shall consist of entitlement to have payment made on his behalf or, in the case of payments referred to in section 1814(d)(2) to him (subject to the provisions of this part) for—

(1) inpatient hospital services for up to 150 days during any spell of illness minus one day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services for up to 100 days during any spell of illness; and

[(3) post-hospital home health services for up to 100 visits (during the one-year period described in section 1861(n)) after the beginning of one spell of illness and before the beginning of the next.]

(3) home health services.

(b) Payment under this part for services furnished an individual during a spell of illness may not (subject to subsection (c)) be made for—

(1) inpatient hospital services furnished to him during such spell after such services have been furnished to him for 150 days during such spell minus 1 day for each day of inpatient hospital services in excess of 90 received during any preceding spell of illness (if such individual was entitled to have payment for such services made under this part unless he specifies in accordance with regulations of the Secretary that he does not desire to have such payment made);

(2) post-hospital extended care services furnished to him during such spell after such services have been furnished to him for 100 days during such spell; or

(3) inpatient psychiatric hospital services furnished to him after such services have been furnished to him for a total of 190 days during his lifetime.

(c) If an individual is an inpatient of a psychiatric hospital on the first day of the first month for which he is entitled to benefits under this part, the days on which he was an inpatient of such a hospital in the 150-day period immediately before such first day shall be included in determining the number of days limit under subsection (b)(1) insofar as such limit applies to (1) inpatient psychiatric hospital serv-

ices, or (2) inpatient hospital services for an individual who is an inpatient primarily for the diagnosis or treatment of mental illness (but shall not be included in determining such number of days limit insofar as it applies to other inpatient hospital services or in determining the 190-day limit under subsection (b)(3)).

[(d) Payment under this part may be made for post-hospital home health services furnished an individual only during the one-year period described in section 1861(n) following his most recent hospital discharge which meets the requirements of such section, and only for the first 100 visits in such period. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items or services described in section 1861(m), shall be determined in accordance with regulations.]

(e) For purposes of subsections (b), [(c), and (d)] *and (c)*, inpatient hospital services, inpatient psychiatric hospital services, and post-hospital extend care services *and* [and post-hospital home health services] shall be taken into account only if payment is or would be, except for this section or the failure to comply with the request and certification requirements of or under section 1814(a), made with respect to such services under this part.

(f) For definition of "spell of illness", and for definitions of other terms used in this part, see section 1861.

* * * * * * *

Conditions of and Limitations on Payment for Services

Requirement of Requests and Certifications

Sec. 1814. (a) Except as provided in subsections (d) and (g) and in section 1876, payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 and only if—

* * * * * * *

(2) physician certifies (and recertifies, where such services are furnished over a period of time, in such cases, with such frequency, and accompanied by such supporting material, appropriate to the case involved, as may be provided by regulations, except that the first of such recertifications shall be required in each case of inpatient hospital services not later than the 20th day of such period) that—

* * * * * * *

(D) in the case of [post-hospital] home health services, such services are or were required because the individual is or was confined to his home (except when receiving items and services referred to in section 1861(a)(7)) and needed skilled nursing care on an intermittent basis, or physical or speech therapy, [for any of the conditions with respect to which he was receiving inpatient hospital services (or services which would constitute inpatient hospital services if the institution met the requirements of paragraphs (6) and (9) of section 1861(e)) or post-hospital extended care services]; a plan for furnishing such services to such individual has been estab-

lished and is periodically reviewed by a physician; and such services are or were furnished while the individual was under the care of a physician; or

* * * * * * *

Payment for [Posthospital] Home Health Services

(i)(1) An individual shall be presumed to require the services specified in subsection (a)(2)(D) of this section for purposes of making payment to a home health agency (subject to the provisions of section 1812) for [posthospital] home health services furnished by such agency to such individual if—

(A) the certification and plan referred to in subsection (a)(2)(D) of this section are submitted in timely fashion prior to the first visit by such agency,

(B) such certification states that the medical condition of the individual is a condition designated in regulations, and

(C) there is compliance with such other requirements and procedures may be specified in regulations,

but only for services furnished during such limited numbers of visits with respect to such conditions of the individual as may be prescribed in regulations by the Secretary, taking into account the medical severity of such conditions, the degree of incapacity, and the minimum period of home confinement generally needed for such conditions, and such other factors affecting the type of care to be provided as the Secretary deems pertinent.

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Part B—Supplementary Medical Insurance Benefits for the Aged and Disabled

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Scope of Benefits

Sec. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph (2); and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) home health services [for up to 100 visits during a calendar year];

(B) medical and other health services furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) physician services except where furnished by—

(I) a resident or intern of a hospital, or

(II) a physician to a patient in a hospital which has a teaching program approved as specified in paragraph (6) of section 1861(b) (including services in conjunction with the teaching programs of

such hospital whether or not such patient is an inpatient of such hospital), unless either clause (A) or (B) of paragraph (7) of such section is met, and

(ii) services for which payment may be made pursuant to section 1835(b)(2); and

(C) outpatient physical therapy services, other than services to which the next to last sentence of section 1861(p) applies; and

(D) rural health clinic services.

Payment of Benefits

Sec. 1833. (a) * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $60; except that (1) the amount of the deductible for such calendar year as so determined shall first be reduced by the amount of any expenses incurred by such individual in the last three months of the preceding calendar year and applied toward such individual's deductible under this section for such preceding year, [and] (2) such total amount shall not include expenses incurred for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology, *and (3) such total amount shall not include expenses incurred for diagnostic tests with respect to which the provisions of subsection (a)(1)(D) are applicable.* The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence.

* * * * * * *

(f)(1) In the case of durable medical equipment to be furnished an individual as described in section 1861(s)(6), the Secretary shall determine, on the basis of such medical and other evidence as he finds appropriate (including certification by the attending physican with respect to expected duration of need), whether the expected duration of the medical needs for the equipment warrants a presumption that

purchase of the equipment would be less costly or more practical than rental. If the Secretary determines that such a presumption does exist, he shall require that the equipment be purchased, on a lease-purchase basis or otherwise, and shall make payment in accordance with the lease-purchase agreement (or in a lump sum amount if the equipment is purchased other than on a lease-purchase basis); except that the Secretary may authorize the rental of the equipment notwithstanding such determination if he determines that the purchase of the equipment would be inconsistent with the purposes of this title or would create an undue financial hardship on the individual who will use it.

(2) with respect to purchases of used durable medical equipment, the Secretary may waive the 20 percent coinsurance amount applicable under subsection (a) whenever the purchase price of the used equipment is at least 25 percent less than the reasonable charge for comparable new equipment.

[(3) For purposes of paragraph (1), the Secretary may, pursuant to agreements made with suppliers of durable medical equipment, establish reimbursement procedures which he finds to be equitable, economical, and feasible.]

(3) For purposes of determining the amount payable with respect to durable medical equipment furnished an individual as described in section 1861(s)(6), the Secretary shall, to the extent feasible, calculate at least annually the reasonable charge on a prospective basis and shall take into account, in addition to the customary and prevailing charges for such equipment, the acquisition costs of such equipment, appropriate overhead (taking into consideration the level of delivery services and other necessary services actually provided by the supplier), and a reasonable margin of profit.

(4) The Secretary shall encourage suppliers of durable medical equipment to make their equipment available to individuals entitled to benefits under this title on a lease-purchase basis whenever possible.

* * * * * * *

[Limitation on Home Health Services

[**Sec. 1834.** (a) Payment under this part may be made for home health services furnished an individual during any calendar year only for 100 visits during such year. The number of visits to be charged for purposes of the limitation in the preceding sentence, in connection with items and services described in section 1861(m), shall be determined in accordance with regulations.

[(b) For purposes of subsection (a), home health services shall be taken into account only if payment under this part is or would be except for this section or the failure to comply with the request and certification requirements of or under section 1835(a), made with respect to such services.]

* * * * * * *

Use of Carriers for Administration of Benefits

Sec. 1842. (a) * * *
(b)(1) * * *

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f)) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the years in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part; and

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In

determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

[No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning July 1 of each year) in which the bill is submitted or the request for payment is made. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted on request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Nothwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on July 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.]

(4)(A) *In determining the reasonable charge for services for purposes of paragraph (3) (including the services of any hospital-associated physicians), there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.*

(B)(i) *Except as otherwise provided in clause (iii), no charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (I) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (II) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made.*

(ii) In the case of physician services, the prevailing charge level determined for purposes of clause (i)(II) for any fiscal year beginning after June 30, 1973, may not (except as otherwise provided in clause (iii)) exceed (in the aggregate) the level determined under such clause for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. Moreover, for any twelve-month period beginning on July 1 of any year (beginning with 1979), no prevailing charge level for physicians' services shall be increased to the extent that it would exceed by more than one-third the statewide prevailing charge level (as determined under subparagraph (E)) for that service.

(iii) Notwithstanding the provisions of clauses (i) and (ii) of this subparagraph, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such clauses for the fiscal year beginning July 1, 1975, shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975.

(C) In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reaonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under circumstances specified by the Secretary. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality.

(D) The requirement in paragraph (3)(B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of

the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected.

(E) The Secretary shall determine separate statewide prevailing charge levels for each State that, on the basis of statistical data and methodology acceptable to the Secretary, would cover over 50 percent of the customary charges made for similar services in the State during the last preceding calendar year elapsing prior to the start of the fiscal year in which the bill is submitted or the request for payment is made. In States with more than one carrier, the statewide prevailing charge level shall be the weighted average of the fiftieth percentiles of the customary charges of each carrier.

(F) Notwithstanding any other provision of this paragraph, any charge for any particular service or procedure performed by a doctor of medicine or osteopathy shall be regarded as a reasonable charge if—

(i) the service or procedure is performed in an area which the Secretary has designated as a physician shortage area,

(ii) the physician has a regular practice in the physician shortage area,

(iii) the charge does not exceed the prevailing charge level as determined under subparagraph (B), and

(iv) the charge does not exceed the amount generally charged by such physician for similar services.

(G) For additional exclusions from reasonable cost and reasonable charge see section 1130.

[(4)] *(5)* Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] *(6)* No payment under this part for a service provided to any individual shall (except as provided in section 1879) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of

attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of compotent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

State Agreements for Coverage of Eligible Individuals Who Are Receiving Money Payments Under Public Assistance Programs (or Are Eligible for Medical Assistance)

Sec. 1843. (a) * * *

(1) Any State, which prior to the date of enactment of this subsection—

(A) has not entered into an agreement under the preceding provisions of this section, may enter into such an agreement at any time within the twelve-month period which begins with the month following the month in which this subsection is enacted, and any such agreement shall conform to the modifications prescribed by the Secretary (as referred to in the third sentence of subsection (b)) and may, at the option of the State, contain any provision authorized under subsections (g) and (h) with respect to modifications of agreements with States entered into under the preceding provisions of this section; or

(B) has entered into an agreement under the preceding provisions of this section which has not been modified pursuant to the authority contained in subsection (g) or (h), may within the twelve-month period which begins with the month following the month in which this subsection is enacted modify such agreement in like manner as if the date referred to in subsection (g)(1) and (h)(1) were the day following the close of such twelve-month period.

* * * * * * *

SPECIAL PROVISIONS RELATING TO CERTAIN SURGICAL PROCEDURES PERFORMED ON AN AMBULATORY BASIS

Sec. 1845. (a) The Secretary shall, in consultation with the National Professional Standards Review Council and appropriate medical organizations, specify those surgical procedures which can be safely and appropriately performed either in a hospital on an inpatient basis or on an ambulatory basis—

(1) in a physician's office; or

(2) in an ambulatory surgical center or hospital.

(b)(1) If a physician performs in his office a surgical procedure specified by the Secretary pursuant to subsection (a)(1) on an indi-

vidual insured for benefits under this part, he shall, notwithstanding any other provision of this part, be entitled to have payment made under this part equal to—

(A) 100 percent of the reasonable charge for the services involved with the performance of such procedure (including all pre- and post-operative physicians' services performed in connection therewith), plus

(B) the amount established by the Secretary pursuant to paragraph (2),

but only if the physician agrees with such individual to be paid on the basis of an assignment under the terms of which the reasonable charge for such services is the full charge therefor.

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(1), an amount established with a view to according recognition to the special costs, in excess of usual overhead, which physicians incur which are attributable to securing, maintaining, and staffing the facilities and ancillary services appropriate for the performance of such procedure in the physician's office, and to assuring that the performance of such procedure in the physician's office will involve substantially less total cost than would be involved if the procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure periodically shall be reviewed and revised and may be adjusted, when appropriate, by the Secretary to take account of varying conditions in different areas.

(c)(1) Payment under this part may be made to an ambulatory surgical center for ambulatory facility services furnished in connection with any surgical procedure, specified by the Secretary pursuant to subsection (a)(2), which is performed on an individual insured for benefits under this part in an ambulatory surgical center, which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, if such surgical center agrees to accept, in full payment of all services furnished by it in connection with such procedure, the amount established for such procedure pursuant to paragraph (2).

(2) The Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a)(2), a reimbursement amount which is payable to an ambulatory surgical center for its services furnished in connection with such procedure. The amount established for any such surgical procedure shall be established with a view to according recognition to the costs incurred by such centers generally in providing the services involved in connection with such procedure, and to assuring that the performance of such procedure in such a center involves less cost than would be involved if such procedure were performed on an inpatient basis in a hospital. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted by the Secretary, when appropriate, to take account of varying conditions in different areas.

(3) If the physician, performing a surgical procedure (specified by the Secretary under subsection (a)(2)), in a hospital on an outpatient basis or in an ambulatory surgical center with respect to which payment is authorized under the preceding provisions of this subsection,

or a physician performing physicians' services in such center or hospital directly related to such surgical procedure, agrees to accept as full payment for all services performed by him in connection with such procedure (including pre- and post-operative services) an amount equal to 100 percent of the reasonable charge for such services, he shall be paid under this part for such services an amount equal to 100 percent of the reasonable charge for such services.

(d) (1) The Secretary is authorized by regulations to provide that in case a surgical procedure specified by the Secretary pursuant to subsection (a) (2) is performed on an individual insured for benefits under this part in an ambulatory surgical center which meets such health, safety, and other standards as the Secretary shall by regulations prescribe, there shall be paid with respect to the services furnished by such center and with respect to all related services (including physicians services, laboratory, X-ray, and diagnostic services) a single all-inclusive fee established pursuant to paragraph (2), if all parties furnishing all such services agree to accept such fee (to be divided among the parties involved in such manner as they shall have previously agreed upon) as full payment for the services furnished.

(2) In implementing this subsection, the Secretary shall establish with respect to each surgical procedure specified pursuant to subsection (a) (2) the amount of the all-inclusive fee for such procedure, taking into account such factors as may be appropriate. The amount so established with respect to any surgical procedure shall periodically be reviewed and revised and may be adjusted, when appropriate, to take account of varying conditions in different areas.

(e) The provisions of section 1833 (a) and (b) shall not be applicable to express attributable to services to which subsection (b) is applicable, to ambulatory facility services (furnished by an ambulatory surgical center) which the provisions of subsections (c) (1) and (2) are applicable, to physicians' services to which the provisions of subsection (c) (3) are applicable, or to services to which the provisions of subsection (d) are applicable.

Part C—Miscellaneous Provisions

Definition of Services, Institutions, etc.

Sec. 1861. For purposes of this title—

* * * * * * *

[Post-Hospital Home Health Services

[(n) The term "post-hospital home health services" means home health services furnished an individual within one year after his most recent discharge from a hospital of which he was an inpatient for not less than 3 consecutive days or (if later) within one year after his most recent discharge from a skilled nursing facility of which he was an inpatient entitled to payment under part A for post-hospital extended care services, but only if the plan covering the home health services (as described in subsection (m)) is established within 14 days after his discharge from such hospital or skilled nursing facility.]

Physician

(r) The term "physician," when used in connection with the performance of any function or claim, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), [(2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function but only with respect to (A) surgery related to the jaw or any structure contiguous to the jaw or (B) the reduction of any fracture of the jaw or any facial bone, or (C) the certification required by section 1814(a)(2)(E) of this Act,] *(2) a doctor of dentistry or of dental or oral surgery who is legally authorized to practice dentistry by the State in which he performs such function, but only with respect to (A) a function (i) which he is legally authorized to perform as such by the State in which he performs such function, and (ii) which, if performed by an individual described in clause (1), would constitute physicians' services, or (B) the certification required by section 1814(a)(2)(E) of this Act*, (3) except for the purposes of section 1814(a), section 1835, and subsections (j), (k), (m), and (o) of this section, a doctor of podiatry or surgical chiropody, but (unless clause (1) of this subsection also applies to him) only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, and (4) a doctor of optometry who is legally authorized to practice optometry by the State in which he performs such function, but only with respect to *(i)* establishing the necessity for prosthetic lenses, *and (ii) any function with respect to aphakia which he is legally authorized to perform as such by the State in which he performs such function*, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(c)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be

self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services; [and]

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialyis services and supplies; and

(*G*) *antigens* (*subject to reasonable quantity limitations determined by the Secretary*) *prepared by an allergist for a particular patient, including antigens he prepares which are forwarded to another qualified person for administration to the patient by or under the supervision of another physician;*

* * * * * * *

(7) ambulance service (*including ambulance service to the nearest hospital which is* (*A*) *adequately equipped, and* (*B*) *has medical personnel qualified to deal with, and available for the treatment of, the individual's illness, injury, or condition*) where the use of other methods of transportation is contraindicated by the individual's condition, but only to the extent provided in regulations;

* * * * * * *

Reasonable Cost

(v)(1)(A) [The] *Subject to subsection* (*bb*), *the* reasonable cost of any services shall be the cost actually incurred, excluding therefrom any part of incurred cost found to be unnecessary in the efficient delivery of needed health services, and shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services; except that in any case to which paragraph (2) or (3) applies, the amount of the payment determined under such paragraph with respect to the services involved shall be considered the reasonable cost of such services. In prescribing the regulations referred to in the preceding sentence, the Secretary shall consider, among other things, the principles generally applied by national organization or established prepayment or-

ganizations (which have developed such principles) in computing the amount of payment, to be made by persons other than the recipients of services, to providers of services on accountof services furnished to such recipients by such providers. Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, may provide for the establishment of limits on the direct or indirect overall incurred costs or incurred costs of specific items or services or groups of items or services to be recognized as reasonable based on estimates of the costs necessary in the efficient delivery of needed health services to individuals covered by the insurance programs established under this title, and may provide for the use of charges or a percentage of charges where this method reasonably reflects the costs. Such regulations shall (i) take into account both direct and indirect costs of providers of services (excluding therefrom any such costs, including standby costs, which are determined in accordance with regulations to be unnecessary in the efficient delivery of services covered by the insurance programs established under this title) in order that, under the methods of determining costs, the necessary costs of efficiently delivering covered services to individuals covered by the insurance programs established by this title will not be borne by individuals not so covered, and the costs with respect to individuals not so covered will not be borne by such insurance programs, and (ii) provide for the making of suitable retroactive corrective adjustments where, for a provider of services for any fiscal period, the aggregate reimbursement produced by the method of determining costs proves to be either inadequate or excessive.

(B) Such regulations in the case of a hospital or extended care services furnished by proprietary facilities shall include provision for facilities shall include provision for specific recognition of a reasonable return on equity capital, including necessary working capital, invested in the facility and used in the furnishing of such services, in lieu of other allowances to the extent that they reflect similar items. The rate of return recognized pursuant to the preceding sentence for determining the reasonable cost of any services furnished in any fiscal period shall not exceed [one and one-half times] *the percentages, specified in the next sentence, of* the average of the rates of interest, for each of the months any part of which is included in such fiscal period, on obligations issued for purchase by the Federal Hospital Insurance Trust Fund. *For hospital and skilled nursing facility accounting years beginning before July 1, 1979, the percentage referred to in the previous sentence is 150 percent and for subsequent accounting years, the percentage is—*

(i) 150 percent with respect to a skilled nursing facility;

(ii) 150 percent with respect to a hospital which, during such accounting year, had actual routine operating costs which were greater than the maximum allowable routine operating costs of such hospital as determined under section 1861(bb)(4)(B)(i);

(iii) 250 percent with respect to a hospital which, during such accounting year had actual routine operating costs which were less than the hospital's adjusted per diem target rate for

routine operating costs as determined under section 1861(bb)(4); and

(iv) 200 percent with respect to other hospitals.

(8) For additional requirements applicable to determination of reasonable cost for services provided by hospitals, see subsection (bb).

(9) for Additional exclusions from reasonable cost and reasonable charge see section 1130.

* * * * * * *

Institutional Planning

[(z) An overall plan and budget of a hospital, extended care facility, or home health agency shall be considered sufficient if it—

[(1) provides for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared, in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

[(2) provides for a capital expenditures plan for at least a 3-year period (including the year to which the operating budget described in subparagraph (1) is applicable) which includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure in exess of $100,000 related to the acquisition of land, the improvement of land, buildings, and equipment, and the replacement, modernization, and expansion of the buildings and equipment which would, under generally accepted accounting principles, be considered capital items;

[(3) provides for review and updating at least annually; and

[(4) is prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the institution or agency.]

(z) An overall plan and budget of a hospital, skilled nursing facility, or home health agency shall—

(1) provide for an annual operating budget which includes all anticipated income and expenses related to items which would, under generally accepted accounting principles, be considered income and expense items (except that nothing in this paragraph shall require that there be prepared in connection with any budget an item-by-item identification of the components of each type of anticipated expenditure or income);

(2) provide for a capital expenditures plan for at least a five-year period (including the year to which the operating budget applies) which identifies in detail the sources of financing and the objectives of each anticipated expenditure in excess of $150,000 related to the acquisition of land, improvement of land, buildings, or equipment, and the replacement, modernization, or expansion of the buildings and equipment, and which would, under generally

accepted accounting principles, be considered capital items, and such capital expenditures plan shall be a matter of public record and available in readily accessible form and fashion;

(3) provide for annual review and updating; and

(4) be prepared, under the direction of the governing body of the institution or agency, by a committee consisting of representatives of the governing body, administrative staff, and medical staff, (if any) of the institution or agency.

* * * * * * *

Criteria for Determining Reasonable Cost of Hospital Services

(bb)(1) In order more fairly and effectively to determine reasonable costs incurred in providing hospital services, the Secretary shall, not later than April 1, 1979, after consulting with appropriate national organizations, establish a system of hospital classification under which hospitals furnishing services initially will be classified—

(A) by size, with each of the following groups of hospitals being classified in separate categories: (i) those having more than 5, but fewer than 25, beds (ii) those having more than 24, but fewer than 50, beds, (iii) those having more than 49, but fewer than 100, beds, (iv) those having more than 99, but fewer than 200, beds, (v) those having more than 199, but fewer than 300, beds, (vi) those having more than 299, but fewer than 400, beds, (vii) those having more than 399, but fewer than 500, beds, and (viii) those having more than 499 beds;

(B) by type of hospital, with (i) short-term general hospitals being in a separate category, (ii) hospitals which are primary affiliates of accredited medical schools being in one separate category (without regard to bed size), and (iii) psychiatric, geriatric, maternity, pediatric, or other specialty hospitals being in the same or separate categories, as the Secretary may determine appropriate, in light of any differences in specialty which significantly affect the routine costs of the different types of hospitals;

(C) as rural or urban; and

(D) according to such other criteria as the Secretary finds appropriate, including modification of bed-size categories;

but the system of hospital classification shall not differentiate between hospitals on the basis of ownership.

(2) The term "routine operating costs" used in this subsection does not include—

(A) capital and related costs,

(B) direct personnel and supply costs of hospital education and training programs,

(C) costs of interns, residents, and nonadminisrative physicians,

(D) energy costs,

(E) malpractice insurance expense, or

(F) ancillary service costs.

(3)(A) During the calendar quarter beginning on January 1 of each year, beginning with 1979, the Secretary shall determine, for the hospitals in each category of the system established under paragraph (1),

an average per diem routine operating cost amount which shall (except as otherwise provided in this subsection) be used in determining payments to hospitals.

(B) The determination shall be based upon the amount of the hospitals' routine operating costs for the most recent accounting year ending prior to October 1 of the calendar year preceding the calendar year in which the determination is made. If, for any accounting year which starts on or after July 1, 1979, a hospital's actual routine operating costs are in excess of the amount allowed for purposes of determining payment to the hospital pursuant to this subsection and subsection (v), only one-half of such excess shall be taken into account in making any determination which the Secretary shall make under this paragraph.

(C) In making a determination, the routine operating costs of hospitals in each category shall be divided into personnel and nonpersonnel components.

(D) (i) The personnel and nonpersonnel components of routine operating costs for hospitals in each category (other than for those excluded under clause (ii)) shall be divided by the total number of days of routine care provided by such hospitals to determine the average per diem routine operating cost for such category.

(ii) In making the calculations required by subparagraph (A) the Secretary shall exclude any newly opened hospital (as defined in the second sentence of paragraph (4)(F)), and any hospital which he determines is experiencing significant cost differentials resulting from failure of the hospital fully to meet the standards and conditions of participation as a provider of services.

(E) There shall be determined for each hospital in each category a per diem target rate for routine operating costs. Such target rate shall equal the average per diem routine operating cost amount for the category in which the hospital is expected to be classified during the subsequent accounting year, except that the personnel component shall be adjusted using a wage index based upon general wage levels for reasonably comparable work in the areas in which the hospitals are located. If the Secretary finds that, in an area where a hospital in any category is located for the most recent twelve-month period for which data with respect to such wage levels are available, the wage level for such hospital is significantly higher than such general wage level in that area (relative to the relationship within the same hospital group between hospital wages and such general wages in other areas), then such general wage level in the area shall be deemed equal to the wage level for such hospital, only with respect to the hospital's first accounting year ending on or after July 1, 1979.

(4) (A) (i) The term "adjusted per diem target rate for routine operating costs" means the per diem target rate for routine operating costs plus the percentage increase in costs determined under the succeeding provisions of this subparagraph.

(ii) In determining the adjusted per diem target rate, the Secretary shall add an annual projected percentage increase in the cost of the mix of goods and services (including personnel and nonpersonnel costs) comprising routine operating costs, based on an index composed of approximately weighted indicators of changes in the economy in

wages and prices which are representative of services and goods included in routine operating costs. Where actual changes in such weighted index are significantly different (at least one-half of 1 percentage point) from those projected, the Secretary shall issue corrected target rates on a quarterly basis. At the end of the hospital's accounting year, the target rate shall be adjusted to reflect the actual changes in such weighted index. Adjustments shall also be made to take account of changes in the hospital's classification.

(B) For purposes of payment the amount of routine operating cost incurred by a hospital shall be deemed to be equal—

(i) in the case of a hospital which has actual routine operating costs equal to or greater than that hospital's adjusted per diem target rate for routine operating costs, to the greater of—

(I) the hospital's actual routine operating costs, but not exceeding—

(a) in the case of the first accounting year of any hospital which begins on or after July 1, 1979, and prior to July 1, 1980, an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs, plus (2) 15 percent of the amount described in clause (1), and

(b) in the case of any accounting year after the accounting year described in clause (a), an amount equal to the aggregate of (1) 100 percent of the hospital's adjusted per diem target rate for routine operating costs for such year, plus (2) a dollar amount equal to the dollar amount determined under clause (a)(2) for the category of such hospital, or

(II) the amounts determined for the hospital under division (I) if it had been classified in the bed-size category which contains hospitals closest in bed-size to such hospital's bed-size (with a hospital which has a bed-size that falls halfway between two such categories being considered in the category which contains hospitals with the greater number of beds), but not exceeding the hospital's actual routine operating costs; and

(ii) in the case of a hospithal which has actual routine operating costs which are less than that hospital's adjusted per diem target rate for routine operating costs, to (I) the amount of the hospital's actual routine operating costs, plus (II) the smaller of (a) 5 percent of the hospital's adjusted per diem target rate for routine operating costs, or (b) 50 percent of the amount by which the hospital's adjusted per diem target rate for routine operating costs exceeds the hospital's actual routine operating costs.

(C) Any hospital (other than a newly opened hospital) excluded by the Secretary under paragraph (3)(D)(ii), shall be reimbursed for routine operating costs on the basis of the lesser of (i) actual costs or (ii) the reimbursement determined under this subsection.

(D) On or before April 1 of the year in which the Secretary determines the amount of the average per diem operating cost for each hospital category and the adjusted per diem target rate for each hospital,

the Secretary shall publish the determinations, and he shall notify the hospital administrator and the administrative governing body of each hospital with respect to all aspects of the determination which affect the hospital.

(E) If a hospital is determined by the Secretary to be—

(i) located in an underserved area where hospital services are not otherwise available,

(ii) certified as being currently necessary by an appropriate planning agency, and

(iii) underutilized,

the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the underutilized capacity.

(F) If a newly opened hospital is determined by the Secretary to have greater routine operating costs as a result of the cost patterns associated with newly opened hospitals, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such patterns. For purposes of this subparagraph a "newly opened hospital" means a hospital which has not satisfied the requirements of paragraphs (1) and (7) of subsection (e) of this section (under present or previous ownership) for at least twenty-four months prior to the start of such hospital's accounting year.

(G) If a hospital is determined by the Secretary to have greater routine operating costs as a result of in service on account of consolidation, sharing, or addition of services, where such consolidation, sharing, or addition has been approved by the appropriate State Health Planning and Development Agency or Agencies, the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to such changes in service.

(H) If a hospital satisfactorily demonstrates to the Secretary that, in the aggregate, its patients require a substantially greater intensity of care than generally is provided by the other hospitals in the same category, resulting in unusually greater routine operating costs, then the adjusted per diem target rate shall not apply to that portion of the hospital's routine operating costs attributable to the greater intensity of care required. To the extent that a hospital can demonstrate that it experiences routine operating costs in excess of such costs for hospitals having a reasonably similar mix of patients on account of consistently shorter lengths-of-stay in such hospital, which result from the greater intensity of care provided by such hospital, the excess routine operating costs shall be considered attributable to the greater intensity of care required.

(I) The Secretary may further increase the adjusted per diem target rate applicable in Alaska and Hawaii to reflect the higher prices prevailing in such States.

(J) Where the Secretary finds that a hospital has manipulated its patient mix, or patient flow, or provides less than the normal range and extent of patient services, or that an unusually large proportion of routine nursing service is provided by private-duty nurses, the routine operating costs of that hospital shall be deemed equal to the lesser of (i) the amount determined without regard to this subsection, or (ii) the amount determined under subparagraph (B).

"(5) *Where any provisions of this subsection are inconsistent with section 1861(v), this subsection supersedes section 1861(v).*

"(6)(A) *Notwithstanding any other provision of this Act, in the case of any State which has established a reimbursement system for hospitals, hospital reimbursement in that State under this title and under the State plan approved under title XIX shall, with respect to the services covered by such system, be based on that State system, if the Secretary finds that—*

"(i) *the State has mandated the reimbursement system and it at least applies to the same hospitals in the State, and to the same costs, as the Federal reimbursement reform program established by this subsection;*

"(ii) *every hospital in the State with which there is such a provider agreement conforms to the accounting and uniform reporting requirements of section 1121 of this Act, and furnishes any appropriate reports that the Secretary may require; and*

"(iii) *such State demonstrates to his satisfaction that the total amount payable, with respect to inpatient hospital costs, in the State under this title and under the State plan approved under title XIX will be equal to or less than the amount which would otherwise be payable for such costs under this title and such State plan.*

If the Secretary finds that any of the above conditions in a State which previously met them have not been met for a two-year period, the Secretary shall, after due notice, reimburse hospitals in that State according to the provisions of this Act (other than this paragraph) unless he finds that unusual, justifiable and nonrecurring circumstances led to the failure to comply.

(B) If the Secretary finds that, during any two-year period during which hospital reimbursement under this title and under the State plan approved under title XIX was based on a State system as provided in subparagraph (A), the amount payable by the Federal Government under such titles for inpatient hospital costs in such State was in excess of the amount which would have been payable for such costs in such State if reimbursement had not been based on the State system (as estimated by the Secretary), the adjusted per diem target rate for routine operating costs (as determined under the preceding paragraphs of this subsection) for hospitals in such State shall be reduced (by not more than 1 percent in any year) until the Federal Government has recouped an amount equal to such excess payment amount.

(C)(i) The Secretary shall pay to any State in which hospital reimbursement under this title is based on a State system as provided in subparagraph (A), an amount which bears the same ratio to the total cost of administering the State system (including the cost of initially putting the system into operation) as the amount paid by the Federal Government under this title in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system.

(ii) Payments under clause (i) shall be made from funds in the Federal Hospital Insurance Trust Fund.

(iii) An amount which bears the same ratio to the total cost of administering the State system (including the cost of initially putting

the system into operation) as the amount paid under the State plan approved under title XIX in such State for inpatient hospital costs bears to the total amount of inpatient hospital costs in such State which are subject to the State system, shall, for purposes of title XIX, be considered to be an amount expended for the administration of such State plan.

Hospital Providers of Extended Care Services

(cc) (1) (A) Any hospital (other than a hospital which has in effect a waiver of the requirement imposed by subsection (e) (5)) which has an agreement under section 1866 may (subject to paragraph (2)) enter into an agreement with the Secretary under which its inpatient hospital facilities may be used for the furnishing of services of the type which, if furnished by a skilled nursing facility, would constitute posthospital extended care services.

(B) (i) Notwithstanding any other provision of this title, payment to any hospital for services furnished under an agreement entered into under this subsection shall be based upon the reasonable cost of the services as determined under this subparagraph.

"(ii) The reasonable cost of the services shall consist of the reasonable cost of routine services and ancillary services. The reasonable cost of routine services furnished during any calendar year by a hospital under an agreement under this subsection shall equal the product of the number of patient-days during the year for which the services were furnished and the average reasonable cost per patient-day. The average reasonable cost per patient-day shall be established as the average rate per patient-day paid for routine services during the previous calendar year under the State plan (of the State in which the hospital is located) approved under title XIX to skilled nursing facilities located in such State and which meet the requirements specified in section 1902(a) (28). The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided as inpatient hospital services.

(2) The Secretary shall not enter into an agreement under this subsection with any hospital unless—

(A) the hospital is located in a rural area and has less than 50 beds, and

(B) the hospital has been granted a certificate of need for the provision of long-term care services from the agency of the State (which has been designated as the State health planning and development agency under an agreement pursuant to section 1521 of the Public Health Service Act) in which the hospital is located.

(3) An agreement with a hospital entered into under this section shall, except as otherwise provided under regulations of the Secretary, be of the same duration and subject to termination on the same conditions as are agreements with skilled nursing facilities under section 1866, and shall, where not inconsistent with any provision of this subsection, impose the same duties, responsibilities, conditions, and limitations, as those imposed under such agreements entered into under section 1866; except that no such agreement with any hospital shall be in effect for any period during which the hospital does not have in

effect an agreement under section 1866, or during which there is in effect for the hospital a waiver of the requirement imposed by subsection (e)(5). A hospital with respect to which an agreement has been terminated shall not be eligible to undertake a new agreement until a two-year period has elapsed from the termination date.

(4) Any agreement with a hospital under this subsection shall provide that payment for services will be made only for services for which payment would be made as posthospital extended care services if those services had been furnished by a skilled nursing facility under an agreement entered into under section 1866, and any individual who is furnished services for which payment may be made under an agreement shall, for purposes of this title (other than this subsection), be deemed to have received posthospital extended care services in like manner and to the same extent as if the services furnished by a skilled nursing facility under an agreement under section 1866.

(5) During a period for which a hospital has in effect an agreement under this subsection, in order to allocate routine costs between hospital and long-term care services for purposes of determining payment for inpatient hospital services (including the application of reimbursement limits specified in section 1816(bb)), the total reimbursement received for routine services from all classes of long-term care patients, including title XVIII, the State plan approved under title XIX, and private pay patients, shall be subtracted from the hospital's total routine costs before calculations are made to determine title XVIII reimbursement for routine hospital services.

(6) During any period during which an agreement is in effect with a hospital under this subsection, the hospital shall, for services furnished by it under the agreement, be considered to satisfy the requirements, otherwise required, of a skilled nursing facility for purposes of the following provisions: sections 1814(a)(2)(C), 1814(a)(6), 1814(a)(7), 1814(h), 1861(a)(2), 1861(i), 1861(j) (except 1861(j)(12)), and 1861(n); and the Secretary shall specify any other provisions of this Act under which the hospital may be considered as a skilled nursing facility.

(7) Within three years after the date of enactment of this subsection, the Secretary shall provide a report to the Congress containing an evaluation of the program established under this subsection concerning—

(A) the effect of the agreements on availability and effective and economical provision of long-term care services;

(B) whether the program should be continued; and

(C) whether eligibility should be extended to other hospitals, regardless of bed size or geographic location, where there is a shortage of long-term care beds.

* * * * * * *

Agreements With Provisions of Services

Sec. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this title (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this title or for which such provider is paid pursuant to the provisions of section 1814(e)), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this title because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person, and

(D) to promptly notify the Secretary of its employment of an individual who, at any time during the year preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity (as determined by the Secretary by regulation) by an agency or organization which serves as a fiscal intermediary or carrier (for purposes of part A or part B, or both, of this title) with respect to the provider.

(E) not to increase amounts due from any individual, organization, or agency in order to offset reductions made under section 1861(bb) in the amount paid, or expected to be paid, under this title.

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this title and regulations thereunder.

* * * * * * *

(c)(1) Where an agreement filed under this title by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this title unless the Secretary finds that the reason for the termination has been removed and that there is reasonable assurance that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this title and title XIX, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1910[(a)], and the term of any

such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.

(3) No agreement under this section with a skilled nursing facility shall, after the date of enactment of this paragraph, be entered into, extended, or renewed, if the State in which such facility is located has a State plan—

(A) which is approved under title XIX, and

(B) which covers skilled nursing facility services,

unless such facility has in effect an agreement, with the State agency administering or supervising the administration of such State plan, under which the skilled nursing services furnished by such facility will be available on a non-discriminatory basis) to individuals covered for medical assistance under such State plan.

* * * * * * *

Health Insurance Benefits Advisory Council

[**Sec. 1867.** (a) There is hereby created a Health Insurance Benefits Advisory Council which shall consist of 19 persons, not otherwise in the employ of the United States, appointed by the Secretary without regard to the provisions of title 5, United States Code, governing appointments in the competitive services. The Secretary shall from time to time appoint one of the members to serve as Chairman. The members shall include persons who are outstanding in fields related to hospital, medical, and other health activities, persons who are representative of organizations and associations of professional personnel in the field of medicine, and at least one person who is representative of the general public. Each member shall hold office for a term of four years, except that any member appointed to fill a vacancy occurring prior to the expiration of the term for which his predecessor was appointed shall be appointed for the remainder of such term. A member shall not be eligible to serve continuously for more than two terms. Members of the Advisory Council, while attending meetings or conferences thereof or otherwise serving on business of the Advisory Council, shall be entitled to receive compensation at rates fixed by the Secretary, but not exceeding $100 per day, including traveltime, and while so serving away from their homes or regular places of business they may be allowed travel expenses, including per diem in lieu of subsistence, as authorized by section 5703 of title 5, United States Code, for persons in the Government service employed intermittently. The Advisory Council shall meet as the Secretary deems necessary, but not less than annually.

[(b) It shall be the function of the Advisory Council to provide advice and recommendations for the consideration of the Secretary on matters of general policy with respect to this title and title XIX.]

AGREEMENTS WITH PHYSICIANS TO ACCEPT ASSIGNMENTS

SEC 1868. (a) For purposes of this section the term "participating physician" means a doctor of medicine or osteopathy who has in effect an agreement with the Secretary by which he agrees to accept an assignment of claim (as provided for in section 1842(b)(3)(B)(ii)) for each physicians' service (other than those excluded from coverage

by section 1862) performed by him in the United States for an individual enrolled under part B. The assignment shall be in a form prescribed by the Secretary. The agreement may be terminated by either party upon 30-days' notice to the other, filed in a manner prescribed by the Secretary.

(b) To expedite processing of claims from participating physicians, the Secretary shall establish procedures and develop appropriate forms under which—

(1) each physician will submit his claims on one of alternative simplified approved bases including multiple listing of patients, and the Secretary shall act to assure that these claims are processed expeditiously, and

(2) the physician shall obtain from each patient enrolled under part B (except in cases where the Secretary finds it impractical for the patient to furnish it) and shall make available at the Secretary's request, a signed statement by which the patient (A) agrees to make an assignment with respect to all services furnished by the physician and (B) authorizes the release of any medical information needed to review claims submitted by the physician.

(c)(1) Participating physicians shall be paid administrative cost-savings allowances (as determined under paragraph (2)) in addition to the reasonable charges that are payable.

(2) The administrative cost-saving allowance shall be $1 for each claim the participating physician submits in accordance with the simplified billing procedure referred to in subsection (b) and these payments shall be treated as an administrative expense to the medical insurance program, except that—

(A) not more than $1 shall be payable to a physician for claims for services furnished to any particular patient within any 7-day period;

(B) no administrative cost-savings allowance shall be payable for services performed for a hospital inpatient or outpatient unless:

(i) the services are surgical services, anesthesia services, or services performed by a physician who, as an attending or consulting physician, personally examined the patient and whose office or regular place of practice is located outside a hospital, and

(ii) the physician ordinarily bills directly (and not through such hospital) for his services; and

(C) no administrative cost-savings allowance shall be payable for services which consist solely of laboratory or X-ray services which are for hospital inpatients or outpatients or are performed outside the office of the participating physician.

Determinations; Appeals

Sec. 1869. (a) The determination of whether an individual is entitled to benefits under part A or part B, and the determination of the amount of benefits under part A, shall be made by the Secretary in accordance with regulations prescribed by him.

(b)(1) Any individual dissatisfied with any determination under subsection (a) as to—

(A) whether he meets the conditions of section 226 of this Act or section 103 of the Social Security Amendments of 1965, or

(B) whether he is eligible to enroll and has enrolled pursuant to the provisions of part B of this title, or section 1818, or section 1819, or

(C) the amount of benefits under part A (including a determination where such amount is determined to be zero).

shall be entitled to a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

(2) Notwithstanding the provisions of subparagraph (C) of paragraph (1) of this subsection, a hearing shall not be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $100; nor shall judicial review be available to an individual by reason of such subparagraph (C) if the amount in controversy is less than $1,000.

(c) Any institution or agency dissatisfied with any determination by the Secretary that it is not a provider of services, or with any determination described in section 1866(b)(2), shall be entitled to a hearing thereon by the Secretary (after reasonable notice and opportunity for hearing) to the same extent as is provided in section 205(b), and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). *If the Secretary's determination terminates a provider with an existing agreement pursuant to section 1866(b)(2), or if such determination consists of a refusal to renew an existing provider agreement, the provider's agreement shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a final decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients and if the Secretary certifies that the provider has been notified of such deficiencies and has failed to correct them.*

Overpayments on Behalf of Individuals and Settlement of Claims for Benefits on Behalf of Deceased Individuals

Sec. 1870. (a) * * *

* * * * * * *

(f) If an individual who received medical and other health services for which payment may be made under section 1832(a)(1) dies, and—

(1) no assignment of the right to payments was made by such individual before his death, and

(2) payment for such services has not been made,

[payment for such services shall be made to the physician or other person who provided such services, but payment shall be made under this subsection only in such amount and subject to such conditions as would have been appreciable if the individual who received the

services had not died, and only if the person or persons who provided the services agrees that the reasonable charge is the full charge for the services.]

payment for such services shal be made (but only in such amount and subject to such conditions as would have been applicable if the individual who received the services had not died) to—

"(A) the physician or other person who provided such services, but only on the condition that such physician or person agrees that the reasonable charge is the full charge for the services, or

"(B) the spouse or other legally designated representative of such individual, but only if (i) the condition specified in subparagraph (A) is not met, and (ii) such spouse or representative requests (in such form and manner as the Secretary shall by regulations prescribe) that payment be made under this subparagraph.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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State Plans for Medical Assistance

Sec. 1902. (a) A State plan for medical assistance must—

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(13) provide—

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[(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII; and]

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, applying the methods specified in section 1861(v) and section 1861(bb), which are consistent with section 1122; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis (*and which may, at the option of the State, include reasonable allowances for the facilities in the form of incentive payments related to efficient performance*), as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary; and

* * * * * * *

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance

(including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services; and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that the State (or any political subdivision thereof) (*A*) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization, or by reason of the fact that the plan provides for payment for rural health clinic services only if those services are provided by a rural health clinic, *or* (*B*) *during the three-year period beginning on the date of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act, has made arrangements through a competitive bidding process or otherwise for the purchase of laboratory services referred to in section 1905(a)(3), if the Secretary has found that* (*i*) *adequate services will be available under such arrangements,* (*ii*) *such laboratory services will be provided only through laboratories* (*I*) *which meet the requirements of section 1861(e)(9), paragraphs (10) and (11) of section 1861(s), and such additional requirements as the Secretary may require, and* (*II*) *no more than 75 per centum of whose charges for such services are for services provided to individuals who are entitled to benefits under this title or under part A or part B of title XVIII, and* (*iii*) *charges for services provided under such arrangements are made at the lowest rate charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) for comparable services by the provider of such services, or, if charged for on a unit price basis, such charges result in aggregate expenditures not in excess of expenditures that would be made if charges were at the lowest rate charged for comparable services by the provider of such services;*

* * * * * * *

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, [and] (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request, *and* (*C*) *not to increase amounts due from any individual, organization, or agency in order to offset reductions made pursuant to the requirements contained in section 1902(a)(13)(D) in the amount paid, or expected to be paid under the State plan;*

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1861(j), except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this title, *and provide that any laboratory services (other than such services provided in a physician's office) paid for under such plan must be provided by a laboratory which during the three-year period beginning on the date of enactment of the Medicare-Medicaid Administrative and Reimbursement Reform Act meets the requirements of section 1861(e)(9), paragraphs (10) and (11) of section 1861(s) or, in the case of a rural health clinic, subsection 1861(aa)(2)(G)*;

(29) include a State program which meets the requirements set forth in section 1908, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care*; and, in the case of laboratory services referred to in section 1905(a)(3), such payments do not exceed the lowest amount charged (determined without regard to administrative costs which are related solely to the method of reimbursement for such services) to any person or entity for such services by that provider of laboratory services*;

* * * * * * *

(39) provide that, subject to subsection (g), whenever the single State agency which administers or supervises the administration of the State plan is notified by the Secretary under section 1862(e)(2)(A) that a physician or other individual practitioner has been suspended from participation in the program under title XVIII, the agency shall promptly suspend such physician or practitioner from participation in the plan for not less than the period specified in such notice, and no payment may be made under the plan with respect to any item or service furnished by such physician or practitioner during the period of the suspension under this title; [and].

(40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1121(a) to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization[.]

(41) contain provisions reasonably directed at the denial of eligibility for medical assistance under the States plan to an individual who would be ineligible for such assistance except for

the transfer of assets, for substantially less than fair market value; except that such denial shall be made only to the extent authorized under the last sentence of section 1904 or under other provisions of this title; and

(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under part A of title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such title, and (C) for payment of the portion of the costs of each such common audit of such an entity equal to the portion of the cost of the common audit which is attributable to the program established under this title and which would not have otherwise been incurred in an audit of the program established under title XVIII.

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Payment to States

Sec. 1903. (a) * * *

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(i) Payment under the preceding provisions of this section shall not be made—

(1) with respect to any amount paid for items or services furnished under the plan after December 31, 1972, to the extent that such amount exceeds the charge which would be determined to be reasonable for such items or services under [the fourth and fifth sentences of section 1842(b)(3)] *subparagraphs (B)(ii), (B)(iii), (C), and (F) of section 1842(b)(4)*; or

(2) with respect to any amount paid for services furnished under the plan after December 31, 1972, by a provider or other person during any period of time, if payment may not be made under title XVIII with respect to services furnished by such provider or person during such period of time solely by reason of a determination by the Secretary under section 1862(d)(1) or under clause (D), (E), or (F) of section 1866(b)(2), or by reason of noncompliance with a request made by the Secretary under clause (C)(ii) of such section 1866(b)(2) or under section 1902(a)(38); or

(3) with respect to any amount expended for inpatient hospital services furnished under the plan to the extent that such amount exceeds the hospital's customary charges with respect to such services or (if such services are furnished under the plan by a public institution free of charge or at nominal charges to the public) exceeds an amount determined on the basis of those items (specified in regulations prescribed by the Secretary) included in the determination of such payment which the Secretary finds will provide fair compensation to such institution for such services; or

(4) with respect to any amount expended for care or services furnished under the plan by a hospital or skilled nursing facility

unless such hospital or skilled nursing facility has in effect a utilization review plan which meets the requirements imposed by section 1861(k) for purposes of title XVIII; and if such hospital or skilled nursing facility has in effect such a utilization review plan for purposes of title XVIII, such plan shall serve as the plan required by this subsection (with the same standards and procedures and the same review committee or group) as a condition of payment under this title; the Secretary is authorized to waive the requirements of this paragraph if the State agency demonstrates to his satisfaction that it has in operation utilization review procedures which are superior in their effectiveness to the procedures required under section 1861(k).

* * * * * * *

(*r*) *In the administration of this title, the fact that an individual who is an inpatient of a skilled nursing or intermediate care facility leaves to make visits outside the facility shall not conclusively indicate that he does not need services which the facility is designed to provide; however, the frequency and length of such visits shall be considered, together with other evidence, in determining whether the individual is in need of the facility's services.*

(*s*) *For additional exclusions from reasonable cost and reasonable charge see section 1130.*

(*t*) *Notwithstanding any other provision of this section no payment shall be made to a State with respect to expenditures incurred by it for services in a skilled nursing facility unless such facility has an agreement with the Secretary in effect under section 1866 and such facility has in effect and conforms to a policy (which it shall amply publicize) of not discriminating for admission and treatment purposes against any patient because he is insured for benefits under part A of title XVIII.*

Operation of State Plans

Sec. 1904. If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this title, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1902; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provision;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure). *The Secretary shall not find that a State has failed to comply with the requirements of this title solely because it denies medical assistance to an individual who would be ineligible for such assistance if, in determining whether he is eligible for benefits under title XVI of this Act, or, in the case of an individual who is not included under*

section 1902(a)(13)(B), in determining whether he is eligible for medical assistance under the State plan, there was included in his resources any asset owned by him within the preceding twelve months to the extent that he gave or sold that asset to any person for substantially less than its fair market value for the purpose of establishing eligibility for medical assistance under the State plan (and any such transaction shall be presumed to have been for such purpose unless such individual furnishes convincing evidence to establish that the transaction was for some other purpose).

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[Certification and Approval of Skilled Nursing Facilities and of Rural Health Clinics

[Sec. 1910. (a)(1) Whenever the Secretary certifies an institution in a State to be qualified as a skilled nursing facility under title XVIII, such institution shall be deemed to meet the standards for certification as a skilled nursing facility for purposes of section 1902(a)(28).

[(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any institution which has applied for certification by him as a qualified skilled nursing facility.

[(b)(1) Whenever the Secretary certifies a facility in a State to be qualified as a rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

[(2) The Secretary shall notify the State agency administering the medical assistance plan of his approval or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.]

CERTIFICATION AND APPROVAL OF SKILLED NURSING AND INTERMEDIATE CARE FACILITIES

Sec. 1910. (a) The Secretary shall make an agreement with any State which is willing and able to do so whereby the State health agency or other appropriate State or local agencies (whichever are utilized by the Secretary pursuant to 1864(a)) will be utilized to recommend to him whether an institution in the State qualifies as a skilled nursing facility (for purposes of section 1902(a)(28)) or an intermediate care facility (for purposes of section 1905(c)).

(b) The Secretary shall advise the State agency administering the medical assistance plan of his approval or disapproval of any institution certified to him as a qualified skilled nursing or intermediate care facility for purposes of section 1902(a)(28) or section 1905(c) and specify for each institution the period (not to exceed twelve months) for which approval is granted, except that the Secretary may extend that term for up to two months, provided the health and safety of patients will not be jeopardized, if he finds that an extension is necessary to prevent irreparable harm to the facility or hardship to the facility's patients or if he finds it impracticable within the twelve-

month period to determine whether the facility is complying with the provisions of this title and applicable regulations. The State agency may, upon approval of the Secretary, enter into an agreement with any skilled nursing or intermediate care facility for the specified approval period.

(c) The Secretary may cancel approval of any skilled nursing or intermidiate care facility at any time if he finds that a facility fails to meet the requirements contained in section 1902(a)(28) or section 1905(c), or if he finds grounds for termination of his agreement with the facility pursuant to section 1866(b). In that event the Secretary shall notify the State agency and the skilled nursing or intermediate care facility that approval of eligibility of the facility to participate in the programs established by this title and title XVIII shall be terminated at a time specified by the Secretary. The approval of eligibility of any such facility to participate in the programs may not be reinstated unless the Secretary finds that the reason for termination has been removed and there is reasonable assurance that it will not recur.

(d) Effective July 1, 1979, no payment may be made to any State under this title for skilled nursing or intermediate care facility services furnished by any facility—

(1) which does not have in effect an agreement with the State agency pursuant to subsection (b), or

(2) with respect to which approval of eligibility to participate in the programs established by this title or title XVIII has been terminated by the Secretary and has not been reinstated, except that payment may be made for up to thirty days for skilled nursing or intermediate care facility services furnished to any eligible individual who was admitted to the facility prior to the effective date of the termination.

(e) Any skilled nursing facility or intermediate care facility which is dissatisfied with any determination by the Secretary that it no longer qualifies as a skilled nursing facility or intermediate care facility for purposes of this title shall be entitled to a hearing by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g). Any agreement between such facility and the State agency shall remain in effect until the period for filing a request for a hearing has expired or, if a request has been filed, until a decision has been made by the Secretary; except that the agreement shall not be extended if the Secretary makes a written determination, specifying the reasons therefor, that the continuation of provider status constitutes an immediate and serious threat to the health and safety of patients, and the Secretary certifies that the facility has been notified of its deficiencies and has failed to correct them.

CERTIFICATION AND APPROVAL OF RURAL HEALTH CLINICS

SEC. 1910. (a) Whenever the Secretary certifies a facility in a State to be a qualified rural health clinic under title XVIII, such facility shall be deemed to meet the standards for certification as a rural health clinic for purposes of providing rural health clinic services under this title.

(b) The Secretary shall notify the State agency administering the medical assistance plan of his approval, or disapproval of any facility in that State which has applied for certification by him as a qualified rural health clinic.

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HOSPITAL PROVIDERS OF SKILLED NURSING AND INTERMEDIATE CARE SERVICES

SEC. 1913. (a) Notwithstanding any other provision of this title, payment may be made, in accordance with this section, under an approved State plan for skilled nursing services and intermediate care services furnished by a hospital which has in effect an agreement under section 1861(cc).

(b)(1) Payment to any such hospital, for any skilled nursing or intermediate care services furnished, shall be at a rate equal to the average rate per patient-day paid for routine services during the previous calendar year under the State plan to skilled nursing and intermediate care facilities located in the State in which the hospital is located. The reasonable cost of ancillary services shall be determined in the same manner as the reasonable cost of ancillary services provided for inpatient hospital services.

(2) With respect to any period for which a hospital has in effect an agreement under section 1861(c), in order to allocate routine costs between hospital and long-term care services, the total reimbursement for routine services received from all classes of long-term care patients, including title XVIII, the State plan, and private pay patients, shall be subtracted from the hospital total routine costs before calculations are made to determine reimbursement for routine hospital services under the State plan.

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